MINISTRY OF DEFENCE

FORCES MEDICAL AND DENTAL SERVICES COMMITTEE

FIRST REPORT

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FORCES MEDICAL AND DENTAL SERVICES COMMITTEE

FIRST REPORT

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MEMBERSHIP OF COMMITTEE

The Rt. Hon. Viscount Waverley, G.C.B., G.C.S.I., G.C.I.E., F.R.S. (*Chairman*)

Sir Harold Boldero, D.M., B.Ch., F.R.C.P.

Mr. S. R. Dennison, C.B.E.

Sir Thomas Gardiner, G.C.B., G.B.E.

Sir Arthur Porritt, K.C.M.G., C.B.E., F.R.C.S.

General Sir James Steele, G.C.B., K.B.E., D.S.O., M.C.

Mr. E. P. Donaldson, C.M.G., Ministry of Defence
Mr. J. W. Nicholas, War Office } (*Joint Secretaries*)

TABLE OF CORRESPONDING RANKS

Navy	Army	Air Force
Surgeon Vice-Admiral	Lieutenant-General ...	Air Marshal
Surgeon Rear-Admiral	Major-General	Air Vice-Marshal
Surgeon Captain (after 6 years) ...	Brigadier	Air Commodore
Surgeon Captain	Colonel	Group Captain
Surgeon Commander	Lieutenant-Colonel ...	Wing Commander
Surgeon Lieutenant-Commander ...	Major	Squadron Leader
Surgeon Lieutenant	Captain	Flight Lieutenant
Acting Surgeon Lieutenant ...	Lieutenant	Flying Officer

To: The Rt. Hon. SELWYN LLOYD, C.B.E., T.D., Q.C., M.P.,
Minister of Defence.

SIR,

I. INTRODUCTORY

We were appointed by your predecessor, Earl Alexander of Tunis, as a Committee with the following Terms of Reference:—

> " To review the arrangements for providing medical and dental services for the Armed Forces at home and abroad in peace and war; and to make recommendations ".

These Terms of Reference were announced in a written reply given by the Parliamentary Secretary, Ministry of Defence, in the House of Commons on 1st December, 1953. This announcement had been preceded by a Press Notice issued by the Ministry of Defence on 15th September, 1953, in which the Government's intention to set up the Committee, the name of the Chairman, and the proposed Terms of Reference were made public. The Press Notice, the full text of which is given in Appendix I, also announced the adoption, with effect from 1st October, 1953, of " certain immediate steps which it is hoped will result in increased numbers of medical men being attracted to make a career in the Services ". The interim measures comprised: improved rates of pay for medical officers in the middle ranks (Major to Brigadier in the Army and their equivalents in the other Services*); increased specialist pay in the Navy and the Army, and corresponding advantages for specialists in the Air Force; and a permanent commission grant of £1,500 (taxable) to officers granted regular commissions. Other measures with the same object in view were announced at the same time. Principal amongst these were: posts for retired officers; antedates up to seven years for new entrant doctors according to their civil experience; and the extension of the system of three-year short service commissions, already in operation in the Air Force, to national service officers in the Army. Interim measures of a similar kind were introduced in the case of Service dental officers.

2. We held our first meeting on 2nd December, 1953, and have since then held 56 meetings of the full Committee, besides meetings of two separate Panels of the Committee set up to interview serving officers.

3. On 4th December, 1953, we issued a general invitation to all concerned to submit evidence and received in response written memoranda and offers to contribute oral evidence from a wide variety of sources. Special steps were taken to ensure that we were made acquainted with Service opinion in regard to matters within our Terms of Reference. The evidence we received fell into the following four main categories:—

(a) *Evidence of Service Officers*

We approached the Service Departments with a request that facilities be given for all serving medical and dental officers to submit to us direct written evidence in regard to any matters which they wished to bring to our notice. The Service Departments readily acceded to our request and over one hundred memoranda were received from regular†, short service and national service medical and dental officers in the Navy, Army and Air Force, some of whom were engaged on specialist duties and some on administrative and general duties. A careful analysis

* Where reference is intended to Service ranks of all three Services, Army ranks only are sometimes given for the sake of brevity; the corresponding ranks in the Navy and Air Force will be found in the Table on page iv.

† The expression " regular " is used to describe officers holding permanent commissions in the Navy, Army or Air Force, as opposed to officers who hold short service or national service commissions.

of this evidence, which was obviously particularly valuable, representing as it did the opinions of serving officers in all parts of the world, was made for us by the Social Survey Division of the Central Office of Information. In addition, we took oral evidence from about fifty serving officers. These officers were selected by us partly from among those who submitted memoranda and partly from lists provided by the Service Departments, at our request, containing the names of officers of various ranks and types of commission who were thought likely to be able to help us.

(b) *Evidence of ex-Service Officers*

Among the written memoranda which we received from medical and dental officers who had left the Services, we wish in the first instance to mention the evidence we received from four retired Directors-General of the Army and Air Force medical services. Lieutenant-General Sir Alexander Hood gave us the benefit of his views, both orally and in a written statement, and we received similar evidence from Lieutenant-General Sir Neil Cantlie and Air Marshal Sir Harold Whittingham. Air Marshal Sir Philip Livingston, who is now resident in Canada, was good enough to send us a written memorandum of his views. We attach the greatest value to the evidence of these distinguished officers, based at it was on long experience and detailed knowledge of the problems before us, coupled with a close appreciation of the importance of tradition and corporate loyalty in the medical branches of the Armed Forces.

Two inquiries were carried out on our behalf by the Social Survey Division of the Central Office of Information amongst former medical officers of the Forces. First of all a pilot inquiry, conducted partly by interview and partly by postal questionnaire, was made amongst about 200 doctors who had recently completed their wholetime national service in the Army or who had served in the Royal Army Medical Corps during the 1939–45 war. After examining the report of this pilot survey, we decided that a more extensive investigation would be justified, and accordingly a number of medical men who had completed their national service in one or other of the Armed Forces since 1948 were either interviewed or asked to answer a postal questionnaire. The views of over 600 doctors were obtained in this way. The detailed analysis of this evidence, which was made on our behalf by Mrs. Muriel Harris of the Central Office of Information—to whom we should like to record our indebtedness for a thorough and skilful piece of work—provided us with a summary of the views held by doctors with recent experience of service in the Forces.

(c) *Evidence of Outside Organisations and Individuals*

We have had the advantage of receiving evidence, both oral and written, from a number of outside organisations and individuals interested in the subject matter of our inquiry. A list of these is given in Appendix II, but we would mention here the very valuable contributions by way of written and oral evidence tendered by the Council of the British Medical Association and the Council of the British Dental Association. We are also greatly indebted to the Deans of Medical and Dental Schools, both Metropolitan and Provincial, for the information and opinions which they placed at our disposal.

(d) *Evidence of Government Departments*

A list of the Departments and authorities from whom we received information, orally or in writing, is given in Appendix III and we take this opportunity of expressing our high appreciation of their help. This is specially so in the case of the three Service Departments, the Ministry of Health and the Medical Directors-General of the Navy, Army and

Air Force, upon whose whole-hearted co-operation we were fortunate in being able to rely.

4. We have thus been able to examine a mass of evidence, both written and oral, from a great variety of sources both inside and outside the Armed Forces. The bulk of this evidence has been consciously and deliberately directed towards that part of the subject matter of our inquiry which we have regarded from the outset as the most important and urgent, namely, the recruitment and maintenance of an adequate supply of professionally qualified medical and dental officers for the Armed Forces, and this Report relates in the main to that problem.

5. Our Terms of Reference relate to dental officers as well as to medical officers but it early became apparent that the issues involved were in certain respects fundamentally different as between the professions and we came to the conclusion that it was desirable to deal with medical officers and dental officers separately. The paragraphs which follow relate primarily to medical officers. The position in regard to dental officers is dealt with in Section VI.

Background and Historical Summary

6. In the period following World War I, the medical branches of the Armed Forces experienced great difficulty in recruiting an adequate number of regular medical officers, and in 1931 a Committee under Sir Warren Fisher (then Permanent Secretary of the Treasury) was set up to investigate the causes of this shortage and to suggest means by which the situation could be remedied. The principal recommendations of this Committee as summarised in paragraph 115 of their Report—presented to Parliament in July, 1933. as Command Paper 4394—were as follows:—

"Professional opportunity should be improved:—

(*a*) by eliminating from the establishments to the greatest degree possible posts which provide insufficient professional opportunity, and thus increasing the proportion of an officer's career spent in posts which give interesting professional work, and particularly in hospital posts;

(*b*) by adopting an organisation allowing of a larger proportion of officers specializing, and of their spending a longer period of their career in specialist work;

(*c*) by improving the opportunity of continuing in professional, as distinct from administrative, work as an officer rises to the higher ranks.

The economic advantages of a Service career should be improved, (*a*) by increasing the length of the career; (*b*) by lowering the ages at which promotion to successive ranks takes place; (*c*) by increasing the proportion of officers promoted to the higher ranks, and thus the proportion of officers who retire on the higher pensions appropriate to those ranks; (*d*) by easing and redistributing the burden of overseas service and service afloat."

These recommendations were in the main adopted and, in addition, medical officers in the Army and in the Air Force were relieved of much non-professional work by the appointment of non-medical officers for personnel, supply and accounting duties. In the Navy those duties had for long been performed by non-medical officers of the Supply and Secretariat Branch and other non-professional staff.

7. The measures recommended by the Warren Fisher Committee met with a fair amount of success but with the outbreak of war in 1939 recruitment of regular officers ceased altogether and, when it was resumed after the war, it was found to be adversely affected by a variety of factors, of which the institution of the National Health Service was by far the most important. That Service offers a newly qualified doctor a well paid and settled medical

career in this country, and in an area largely of his own choice. In addition, it makes provision for a pension and a lump sum gratuity at age 65, and for various ancillary benefits—incapacity pension, widow's pension, etc. Thus the National Health Service now provides the security and settled prospects which had in the past been important attractions of a Service career. Further, the National Health Service Act, 1946, by prohibiting the sale of practices, makes it extremely difficult for a retired Service medical officer to obtain a practice, and so accentuates the hardship caused him by retirement, save in exceptional cases, at age 57 or even earlier.

Present Problems

8. As a result of the changed conditions outlined in the previous paragraph, the medical branches of the Forces have been unable to recruit doctors in sufficient numbers to maintain their regular establishments. This is the essential problem which has to be faced. Lack of regular medical officers means not only a shortage of experienced general duty and administrative medical officers but also a serious deficiency in fully qualified specialists*, since specialists must in general be recruited from amongst regular officers because of the length of training which medical officers must undergo before they can be accepted as fully qualified specialists. It is thus essential for the satisfactory organisation of the medical branches that their regular officer cadres should be at or about full strength.

9. The situation in the three Services at 31st March, 1955, is shown in the following Table :—

	Total Requirement	Total Strength			
		Numbers	Percentages		
			Regular	Short Service	National Service
			Per cent.	Per cent.	Per cent.
Navy...	480	457	55	22·5	22·5
Army	1,700	1,596	28	17	55
Air Force	871	796	34·5	32	33·5
Total Armed Forces	3,051	2,849	—	—	—

The position in the Army is particularly disturbing. No less than 55 per cent. of the medical officers hold national service commissions. About 90 per cent. of all general duty medical officers employed in units in the Army are in this category. A preponderance of this order of young and inexperienced medical officers is clearly undesirable. More important, the number of regular officers, even though supplemented by short service officers, is inadequate to provide the necessary specialist services. The Army requires about 275 senior specialists; at present it has only about 180. Although the Air Force has a higher proportion of regular and short service officers than the Army, and is better placed than the Army in regard to the experience of those of its medical officers who are employed in general duty and administrative posts, its problem in regard to the supply of specialists is even more acute than that of the Army. The Air Force requires about 140 specialists and at present has just over 50 in post. In the Navy, the proportion of regular medical officers is substantially higher than it is in the Army or the Air Force and the proportion of national service officers is correspondingly lower. For the time being the position there is less disturbing than it is in either the Army or the Air Force, but it is deteriorating as will be seen below (paragraph 11).

* We define fully qualified specialists in paragraph 63 below.

10. The Medical Directors-General of the Army and Air Force have been reviewing their requirements in the light of this situation. They consider that about 50 per cent. of their permanent needs should be covered by regular officers, which would mean that the Army (with a total establishment reduced from the present requirements) would need between 600 and 700 regular officers and the Air Force between 400 and 450. There are at present about 450 regular officers in the Army and about 275 in the Air Force. The Medical Director-General of the Navy is of the opinion that the conditions of his Service require a higher proportion of regular officers than is needed in the Army or Air Force. He suggests that the proportion should be not less than 70 per cent. of the total establishment, in which event about 320 regular officers would be needed, compared with about 250 at present in post. We do not think that it is desirable at this stage to lay down a rigid proportion of regular officers to total establishment for any of the three Services. We consider that it is better, at least for the time being, to maintain some flexibility, especially in the proportion of regular to short service officers. Officers on short service commissions, particularly those on the longer engagements, can make a substantial contribution the extent of which can only be determined in the light of experience. Whatever view may be taken of these matters, it is, however, clear that a substantial increase in the regular medical cadres of the Army and the Air Force is now urgently required.

11. We have already referred to the interim measures which were introduced from 1st October, 1953 (paragraph 1). These have had an encouraging effect on recruitment to the Army and Air Force. The following Table shows the position:—

		Average 1948–52			Annual Average 1st October, 1953–31st March, 1955		
				Excess of Intake over Loss (+) or of Loss over Intake (—)			Excess of Intake over Loss (+) or of Loss over Intake (—)
Navy	Regular	Intake	7·5	— 3·5	Intake	15	— 7
		Loss...	11		Loss...	22	
	Short Service	Intake	30·8	+14·8	Intake	22·5	—12
		Loss...	16		Loss...	34·5	
Army	Regular	Intake	18	— 8	Intake	41	+19
		Loss...	26		Loss...	22	
	Short Service	Intake	44	+ 3	Intake	112·5	+60
		Loss...	41		Loss...	52·5	
Air Force	Regular	Intake	15	+ 7	Intake	36·5	+29·5
		Loss...	8		Loss...	7	
	Short Service	Intake	46	+31	Intake	62	— 4
		Loss...	15		Loss...	66*	

* The Air Force introduced 3-year short service commissions in 1950, and the rate of intake increased considerably. The increased loss of short service officers in 1953–55 reflect the high intake in 1950–53. The Army did not introduce this type of commission until 1st October, 1953, and this explains the sharp increase in the intake of short service officers since that date.

It will be seen that since October, 1953 intake has substantially exceeded loss for regular and short service officers for the Army and for regular officers for the Air Force. For the Navy, however, loss still exceeds intake in both categories.

12. Although there has been this increase in recruitment for the Army and Air Force, the rate is still inadequate to meet their requirements. It would take another ten years at present rates (even supposing they were to continue) for the Army to reach a satisfactory position in regular officers; the Air Force is in a better position, as present rates would bring the numbers up to requirement in four or five years. Achievement of numbers, however, is merely the first step in the establishment of satisfactory standards of specialist and other services; there would then be a period of several years during which the officers would have to be trained and absorbed into their particular specialities.

13. The evidence seems to us to suggest that the Services will not be able to attract sufficient doctors to provide a well balanced medical service unless and until new entrants can be offered a career which is more satisfying professionally than that which is at present open to them. It is to this matter that, in our view, attention should be primarily directed. It is also in our view important that general conditions of Service life by way of housing, freedom from excessive changes of station, facilities for the education of children and other social amenities should be better than those now available. The emoluments of medical officers generally, though much better than they were previously, are, however, still not wholly satisfactory and seem to us to require review in the light of present day circumstances.

14. The problem of recruitment is thus divided into three main parts which we propose to consider successively. These are:—

Professional aspects (Section III).

General conditions of Service life, particularly the problems of postings, housing and children's education (Section IV).

Organisational matters, including establishment, pay, prospects, etc. (Section V).

Before dealing with these subjects in detail, however, we propose to examine certain matters affecting the constitution and organisation of the medical branches of the Armed Forces as a whole (Section II).

II. CONSTITUTIONAL

Amalgamation of the Medical Branches of the Armed Forces

15. The amalgamation of the medical branches of the three fighting Services into one common organisation has often been suggested as a means of securing economy in medical man-power and increased efficiency of operation. It has been seriously considered by Governments on two occasions in the past thirty years.

16. In 1922 the Cabinet set up a Committee to make definite proposals for amalgamating, as far as possible, certain common services of the Navy, Army and Air Force. These services included the medical branches. The Committee met at first under the chairmanship of Sir Alfred Mond and later under Lord Weir of Eastwood. They reported in 1923, but their Report was not published until 1926 (Command Paper 2649). They found against amalgamation of the three medical branches, on the ground that "so long as the Navy, Army and Air Force are under the executive control of separate Ministers, the amalgamation of their Medical Services

would involve a division of responsibilities which would impair efficiency to such an extent as to outweigh any economies that might thereby be effected." The Committee proposed the establishment of a Joint Committee of the heads of the three medical branches and the Ministry of Pensions, charged with the duty of securing co-ordination of the various services in a number of directions, including the construction of new hospitals, the provision of common facilities for training, and specification of stores and appliances. This Committee was established, and functioned until the outbreak of war in 1939.

17. Immediately after the last war, amalgamation was again carefully considered. The White Paper on Central Organisation for Defence (Command Paper 6923), issued in October, 1946, which contained the Government's proposals for the establishment of a Ministry of Defence, stated that "a study is being made of the possible advantages of drawing together certain administrative services which are now provided separately for each of the three fighting Services, e.g., the medical services, and forming a combined organisation which would provide those services in common for all branches of the Armed Forces". When this statement was published, the study which was referred to was far advanced, and in fact a possible scheme of organisation for a combined medical service had been outlined. This scheme was not adopted, however, and the Statement Relating to Defence (Command Paper 7327) published in February, 1948 stated that "Further examination has not led His Majesty's Government to the conclusion that such a complete amalgamation would be in the real interests of economy and efficiency, either in existing circumstances or in those which are likely to obtain for many years to come. The Government consider, however, that a greater measure of co-ordination between these services is desirable". A new Co-ordinating Committee was therefore established, on a somewhat wider basis than the pre-1939 body, with a chairman from the Ministry of Defence. This Committee is at present responsible for securing co-ordination of the medical services.

18. Proposals for amalgamation were put before us by various witnesses. As they included Sir Alexander Hood, their views are obviously entitled to serious consideration. We have therefore reviewed the position and collected further evidence. Several witnesses drew our attention to the development of co-ordination in Canada, and we have had the benefit of written and oral evidence from Dr. J. A. MacFarlane, the Chairman of the Canadian Forces Medical Council. It is significant that Canada has also considered complete amalgamation and rejected it, although the problems involved there are less intractable than they would be in this country. Instead, a policy of closer co-ordination has been adopted; this, however, is as yet only in its early stages.

19. Many witnesses who favoured amalgamation had been impressed by their war-time experiences, in which considerable economies and increases in efficiency had been achieved by some measure of amalgamation in specific cases. We do not, however, think that the success of joint operations within a limited field can be advanced as a valid argument for amalgamation of the three medical branches. Considerations which may be of minor significance in the isolated case can become of major importance when the unification of the whole of the medical organisations is in question. We regard the examples which have been cited to us as cases of fruitful co-operation, of a kind which we would wish to see adopted wherever circumstances permit, but which are not relevant to the essential issue.

20. We think that there are four dominant considerations, all of which weigh against amalgamation:—

(*a*) Although the three Services have certain medical needs in common, there are other needs which are peculiar to each Service. Obvious examples are aviation medicine for both the Air Force and Navy and submarine physiology for the Navy; the needs of the Army in the field in regard to preventive medicine differ from those of the Navy or the Air Force. It would seem obvious that the specialised needs of each Service can best be met from within that Service rather than from some common organisation which has to cater for all three Services.

(*b*) The tasks and functions of the three Fighting Services are entirely different, and they accordingly have different forms of organisation, each appropriate to its functions. It would seem essential that the medical branch of each Service should be closely integrated with the main organisation of that Service. To have the medical branch organised on a different basis from, and independent of, that of the rest of the Army (or Navy or Air Force) would not result in greater efficiency: it could result in administrative chaos.

(*c*) Each Service Minister is constitutionally responsible for the health and efficiency of his particular Service. In medical matters this goes beyond preventive and curative medicine; it also involves such matters as the design of weapons and equipment, which have important medical aspects on which the medical branches need to be consulted. There are here, of course, different problems for each of the three Services. An amalgamated medical service would presumably have to be responsible to one Minister, possibly the Minister of Defence. It would seem impossible under such an arrangement to avoid division of responsibility, while putting a heavy burden on the Minister of Defence, whose Department is not organised, nor intended to be organised, to assume an administrative task of this kind.

(*d*) Loyalty of the officer to his particular Service is a vital element in the maintenance of morale and therefore of efficiency, and we do not believe that it is any less so for the medical officer than for his combatant colleague. We regard it as important that the doctor who holds a commission should regard himself as an officer as well as a doctor. The traditions and loyalties of each Service should not be lightly cast aside, and we do not see how they could be re-created in a common service. At the very lowest, the difficulties of recruiting suitable men would be increased. Men who are now called to serve in the Navy, Army or Air Force as the case may be, would be unlikely to feel the same attraction to a combined service.

21. The first two considerations above, and to some extent the third, suggest that the economies to be achieved by a combined service might be illusory. A completely common service, providing whatever was needed, and when it was needed, for each of the three Armed Forces from a central pool, would clearly be inadequate; it would be necessary to have various special branches to cater for the special needs of each of the three Services. Although some movement of particular officers among the specialist branches would presumably be possible, each of the Armed Forces would need a substantial hard core which would be more or less permanently attached to it. The organisation would therefore be of a hybrid character, somewhere between the present division into three medical branches and a completely

common service. This is not a form of organisation which is likely to yield substantial administrative economies. Moreover, the three Services could not entirely divest themselves of all the functions and responsibilities which now pertain to their medical branches; at the least they would have to maintain organisations for liaison with the common medical service. There would, therefore, be serious dangers of duplication and overlapping between the central organisation of the common service, its various constituent parts, and the organisations of the three Armed Forces. In the result, the economies in medical manpower would probably be slight.

22. Nor would we expect any gain in efficiency. Indeed, the division of responsibility, together with an increased complexity of administration, might well involve a reduction in efficiency. We consider, in fact, that the fundamental problems are now the same as those found by the Mond-Weir Committee of 1923, and again by the Government in 1946–48, and we do not recommend any measure of amalgamation of the three medical branches.

23. When we turn to co-operation among the three Services, however, the picture is different. We believe that real economies and greater efficiency can be achieved by close co-operation wherever the Services have common problems, and joint action is consistent with their individual organisations and operations. Although much has been achieved in the past thirty years, we consider that still more can be done. This is particularly so at hospital level, where closer co-operation is not only more practicable than it is in some other fields but is also highly desirable on medical and professional grounds. We deal with this matter later (paragraphs 35-36).

Integration with the National Health Service

24. The establishment of the National Health Service has opened the way to a considerable extension of co-operation between civilian medical services and the medical branches of the Armed Forces. We deal in detail later (paragraphs 41–43) with some of the possibilities. We had first, however, to consider suggestions for the amalgamation of the National Health Service with the medical branches of the Armed Forces which were put before us by various witnesses. We have no hesitation in rejecting certain more extreme proposals for the creation of a common service for civilians and the Armed Forces: this would be open to the same objections, though in even greater degree, as those which constitute a conclusive case against amalgamation of the three medical branches of the Armed Forces. A more moderate proposal, for the establishment of common hospital treatment in this country had, however, to be seriously considered. This was suggested to us by several witnesses, including Lord Nathan, who is Chairman of the Board of Governors of Westminster Hospital and who was Parliamentary Under-Secretary of State for War in 1945–46, when amalgamation of the medical branches was under discussion.

25. The proposal was that all Service personnel who require hospital treatment in the United Kingdom should receive it in civilian hospitals. It was suggested to us that this did not in fact involve any new principle. During the last war large numbers of servicemen were treated in civilian hospitals, and this now continues in certain special fields, the treatment of a certain number of cancer cases in the Westminster Hospital being one example. It was not suggested that the medical branches of the Armed Forces should abrogate their functions in regard to hospital treatment: Service doctors and nursing staff would serve in civilian hospitals, without being confined to Service patients. There would, however, no longer be any need for hospitals independently organised and maintained by the Service Departments.

26. This proposal has undoubted attractions. It could achieve economies, and it could make available to specialists in the Armed Forces a range of experience which is at present often denied to them. Nevertheless, it has serious drawbacks which we consider to be of over-riding importance.

27. The first objection arises from the entirely different needs of civilians and Service personnel for hospital treatment. A serviceman with a relatively minor disease or injury, for which the civilian would be treated in his home, must be admitted to hospital. Consequently a large proportion of the Service cases which are treated in Service hospitals would not normally be regarded as requiring such treatment in civilian life. Most civilian hospitals now have long waiting lists; if they were to assume responsibility for Service patients they would have to earmark large numbers of beds for cases which, by civilian standards, could not be regarded as either urgent or serious, and this would inevitably place considerable strain on their administration and also give rise to understandable resentment. Even though in due course tbe pressure on civilian hospitals may be reduced, it would be difficult to justify maintaining in them a permanent reserve of beds at a level sufficient to meet the needs of the Armed Forces. These needs would not only be substantial, but they would be continually varying from place to place and from time to time, according to changes in the disposition of the Armed Forces. Unless this reserve could be guaranteed, the Armed Forces would have to make their own provision for treatment, by such methods as proliferation of sick quarters, which might well be more wasteful than the maintenance of the existing Service hospitals. There has, indeed, already been some experience of this kind. When a soldier or member of his family develops tuberculosis, he becomes the responsibility of the civilian medical authorities in the region of his normal domicile. There is, however, a waiting list not only for admission to sanatoria but also for urgent chest cases requiring immediate surgical treatment. The Army therefore has had to establish its own tuberculosis centres, which in 1952 admitted 552 soldiers and members of soldiers' families.

28. A second objection arises from the fact that a medical officer in the Forces serves part of his time in this country and part overseas, and it is essential for the effective organisation of the medical branches that this should be so. The absorption of Service specialists into civilian hospitals might raise difficulties in the deployment of medical officers in the medical branches. More important, the medical branches might suffer in their professional standards by the removal of hospitals from their control; although the Service specialists actually working in civilian hospitals might well gain by the wider range of experience, the rest of the branches would suffer. We later make alternative proposals for providing Service specialists with wider experience. In general, we consider that the medical branches must be able to maintain their own integral organisation in this country as well as overseas.

29. Finally, a primary function of the Armed Forces is to prepare for war. It is true that in the last war there was close co-operation between the Services and the civilian hospitals, through the Emergency Medical Service, and that the same co-operation would be needed in a future war. Nevertheless, as the last war amply demonstrated, the Armed Forces have their own special medical problems in time of war, and provision must be made to meet them. We are satisfied that this provision can best be made by the maintenance of Service hospitals which are independent of the National Health Service.

30. In the light of these considerations, we are satisfied that the Armed Forces should maintain their own hospitals. Although our conclusion is not thereby determined, we hope that the measures which we later propose (paragraphs 41–43) will result in greater co-operation between the medical branches of the Armed Forces and the National Health Service, in time of peace as well as in war. It is in fuller co-operation that economy should be sought without any sacrifice of the efficiency or integrity of the respective Services.

Co-ordination of Medical Services

31. Since the beginning of 1948 the Medical Services Co-ordinating Committee (paragraph 17) has been responsible for securing co-ordination in matters of common interest to the medical branches of the Armed Forces. The Committee consists of a Chairman provided by the Ministry of Defence and representatives from the Treasury, the Ministry of Health and the three Service Departments. The Service Departments are represented by officers and officials from their personnel and financial branches as well as by their Medical Directors-General. The Committee does not, however, deal with questions of emoluments. The Committee makes recommendations to the Service Ministers' Committee. We have taken evidence from the Chairman of the Committee and have reviewed its work over the past seven years.

32. The Committee has been successful in bringing about a greater degree of co-operation than existed in 1939. In the United Kingdom, it has exercised some supervision over the building programme of hospitals to avoid overlapping. A new system of common documentation for the three Services has been introduced, with a great saving in clerical work; the training of ancillary personnel has been, to some extent, put on a common basis for the three Services; scales of provision of medical equipment have been supervised; certain possibilities of co-operation in research have been examined. In overseas Commands, the Committee has gone further than it has done at home to encourage the pooling of resources, with the adoption wherever possible of the principle that the particular Service which predominates in a given area should assume responsibility for medical treatment of personnel of the other two Services. In each overseas theatre there is an Inter-Service Medical Co-ordinating Committee whose annual reports are scrutinised by the main Committee in this country.

33. The Committee has also encouraged greater co-operation between the medical branches of the Forces and the National Health Service in this country, particularly by extension of the use of civilian hospitals for treatment of Service cases, as well as some use of Service hospitals for civilian cases. Various administrative problems which are raised by this form of co-operation have been considered and solved.

34. In spite of the progress that has been made, we are not satisfied that the fullest degree of co-operation which is possible and desirable is being achieved, either between the three medical branches themselves or between the medical branches and the National Health Service. We have found divergencies of practice among the three Services which we consider unnecessary, and see no reason why they should not be removed. In the immediately following paragraphs we suggest certain directions in which co-ordination between the three medical branches could be extended. We then turn to consider possibilities of collaboration with the National Health Service (paragraphs 41–43). Finally, we recommend the establishment of new machinery (paragraphs 44–45).

35. It is in the organisation of hospitals that we should expect increased inter-Service collaboration to be not only feasible but also to yield the greatest advantages in economy and efficiency. There is already some co-operation in this country. For example, the psychiatric division of 300 beds at the military hospital at Netley serves the Navy and Air Force as well as the Army, and is recognised as a teaching hospital for the higher diploma in psychiatric medicine. We mention this not merely because it is an outstanding case but also because we consider that specialist hospitals are likely to offer greater opportunities for joint action than will be found in general hospitals. There are many other less striking cases in which a hospital belonging to one of the Services accommodates patients from the other two Services as occasion arises; for example, in Northern Ireland, Air Force patients are treated either in a military hospital near Belfast or in Naval Air Station sick quarters: in the Lincoln area, the Air Force hospital at Nocton Hall accommodates Army patients: the Navy and Army use three Air Force Medical Rehabilitation Centres: the naval hospital at Plymouth treats soldiers in the Devonport area, the old military hospital there having been closed. Overseas there is a greater degree of co-operation than in the United Kingdom: for example, there is no Air Force hospital in Malta, patients being admitted to the military hospital or receiving out-patient treatment at the naval hospital; at Aden the Air Force hospital treats all naval and Army cases; at Trincomalee the naval hospital accommodates men from all three Services.

36. Certain witnesses suggested to us that amalgamation of the Service hospitals in this country would be perfectly possible, even though the three medical branches were otherwise to remain independent, with considerable gains in economy and efficiency. Although integration of the hospitals into a common service would be more feasible than complete amalgamation of the three medical branches, it is open to some of the same objections, and we cannot therefore recommend it. We do, however, consider that there should be a marked extension of joint action in the use made of Service hospitals in this country, especially of specialist hospitals. There are two alternative methods of organisation. One is that which is now adopted: namely, that one of the Services should be responsible for the organisation and operation of a hospital which is staffed by its own medical officers. In practice, the responsible Service would be that which has the major interest in the particular hospital. The other alternative is the establishment of hospitals which are controlled by an inter-Service, or even partly independent, body and staffed by medical officers from all three medical branches. This latter alternative is now being adopted in Canada, where two new hospitals are planned near Kingston, Ontario and near Ottawa. They will be controlled in regard to professional policy by the Canadian Forces Medical Council, which has an independent chairman, and staffed by all three Services. Administrative control will be provided by the Army Commander in the particular area. It should be recognised that these hospitals have not yet been built, and that the scheme is still in an experimental stage with many problems of organisation yet to be solved. But it is an experiment which deserves close attention.

37. One suggestion which has been put before us is the establishment by the Services of a specialist hospital for traumatic surgery. The Services have here not only a vital interest but also the opportunity of reaching a degree of professional pre-eminence which is not open to them in many other fields. A hospital of this kind should be sited in an industrial area, so that it could accommodate cases of industrial injuries which, in time of peace, would constitute a large part of its work. We think that

this suggestion deserves serious consideration. Although it is not an essential part of the proposal, a hospital of this kind might serve as an experiment in joint organisation and staffing by the three Services.

38. There is less scope for collaboration among the Services in the day-to-day medical work of individual units than there is in the organisation of hospitals. Nevertheless this is a field in which further economies could be gained. The Medical Services Co-ordinating Committee has not attempted to prescribe specific measures of co-ordination at command level in this country; they investigated the situation in 1949 and 1950 and decided that it was satisfactory, and that a regular series of reports was unnecessary. While it is true that the best machinery might achieve little if the will to co-operate at all levels is lacking, we should prefer to see more formal arrangements to secure that there is no unnecessary duplication of medical facilities. The principle should be accepted that in places where two or more Services maintain establishments, primary responsibility should normally rest with the medical branch of the Service with the larger number of men.

39. The training of medical officers is another field in which co-operation might be developed. Although each Service must make provision for its own special needs, they also have much in common. The Canadian Forces Medical Council has recently established a joint medical training centre which is intended to provide the preliminary training for officers in all three Services on their first entry, and ultimately to include post graduate training and refresher courses. This again is an experiment which should be carefully watched.

40. Finally, we can see possibilities in greater co-operation in research. Each of the three Services has its own special problems and it is essential that each should be free to undertake investigations in those fields in which its primary interests lie. But it is inherent in the nature of this type of research, that diverse problems can have common origins and in various ways impinge on each other. Even here there is therefore a need for consultation among the Services on their research programmes. Moreover, there is often an important link between treatment and investigation; development of greater co-operation in specialist hospitals would therefore imply closer association in research. Beyond this, the Services have many problems in common and for these there is much to be said for a central research institute operated jointly by the three medical branches. We do not, however, specifically recommend this so long as other methods of collaboration can be developed. We are clear that two principles must be observed. The first is freedom for the medical branches to engage in those lines of research which appear to them to be more necessary and fruitful: this is as important as is freedom of action for the individual research worker. Secondly, this freedom needs to be exercised within the framework of a programme which is agreed among the three medical branches and which is carefuly reviewed at frequent intervals.

41. Co-operation between the medical branches of the Armed Forces and the National Health Service in this country is largely a question of the reciprocal use of hospital facilities both by patients and by medical staffs. So far as accommodation of patients is concerned, there is already a certain amount of interchange between the Service and civilian hospitals. The Army and Air Force have always provided treatment for the families of serving men; just under 10 per cent. of the beds in Army hospitals in the United Kingdom, for example, are for women and children. In 1952, Army hospitals treated over 5,000 civilian cases, of whom 3,000 were

dependants of soldiers, and 1,480 civilians employed by the War Department; the others, some 600, were cases of emergency. Against this treatment of civilians in Army hospitals, some 3,800 soldiers were treated in civilian hospitals. The Air Force hospitals now treat over 4,000 civilian patients a year, four-fifths of whom are dependants of servicemen; about the same number of Air Force patients are admitted to National Health Service hospitals. The numbers for the Navy are smaller, not only because it is a smaller Service, but also because the naval medical branch does not undertake to treat families of officers and ratings at Home. This is one change which might forthwith be made, and we recommend that the Navy should adopt the practice of the Army and Air Force in providing medical treatment for Service families at home ports. More generally, we hope that it will prove possible in due course greatly to extend co-operation in the use of hospital beds. The machinery already exists and the obstacles at the present time are largely those of shortages of beds in civilian hospitals and of medical and nursing staff in the Service hospitals. Unfortunately these shortages cannot easily or quickly be made to compensate each other. A greater degree of interchange would, however, bring economy both for civilian and for Service hospitals by helping them to secure fuller utilisation of beds and thus reducing the total provision required.

42. We should like to see an extension of co-operation between the staffs of civilian and Service hospitals at consultant level. It is advantageous for each Service to maintain an advisory panel of civilian consultants of the highest standing who can be brought into consultation in individual cases of exceptional difficulty. It is also desirable that civilian consultants should pay regular visits to the various Service hospitals, not for the purpose of doing the work which should be undertaken by Service specialists, but to discuss with them their clinical problems and to acquaint them with the latest developments in civilian hospital technique. The Army employ a number of paid civilian consultants in place of Service specialists. In present circumstances this arrangement is inevitable because of the serious shortage of specialists in those Services. The practice is, however, open to objection in principle because of its discouraging effect on Service medical officers, and we recommend that it be discontinued as soon as the needs of the case permit.

In another Section of our Report (paragraph 71) we refer to the need for freely seconding Service specialists to civilian hospitals; we attach great importance to this recommendation, the object of which is not only to provide the maximum flexibility of treatment for the patients, but to give Service medical officers wider clinical experience as well as opportunities to work in collaboration with civilian doctors of the highest professional repute.

43. At the general duty officer level, some economy in the Services could be secured by arranging for the treatment of small units, and of servicemen on leave, by civilian practitioners employed on a part-time or a capitation basis. The Services already employ some civilian general practitioners in this way, and it is a system which should be extended whenever opportunity offers. It would not, however, be desirable to employ civilian doctors whole-time in Service units.

44. We have now reviewed various directions in which we consider that co-operation between the three medical branches and between these branches and the National Health Service can be extended. We have been impressed by the willingness of the medical branches to accept further measures of collaboration, so long as they are not impeded in the discharge of their

primary responsibilities and their basic structure is not impaired. The will to co-operate, though essential, is not by itself enough; there must be administrative machinery, which initiates the various schemes and then exercises close supervision over their development. Moreover, as conditions change, new opportunities for collaboration will arise and it is therefore necessary to have in continuous existence an organisation which will ensure that full use is made of them. We therefore recommend the establishment of a new body in place of the present Medical Services Co-ordinating Committee. The weakness of that Committee lies mainly in the absence of an independent element; the body which we envisage should therefore have an independent chairman from outside the public service. It is not essential that the chairman should be medically qualified; what is important is that he should be an independent person of recognised standing and proved administrative capacity. The body should also include two or three civilian doctors of distinguished professional standing. The Service Departments should be represented by their Medical Directors-General and the Ministry of Health by the Chief Medical Officer. As well as these medical representatives, the Committee should include members with experience of administrative and financial matters in the Departments concerned. This Committee should report to a single Minister, presumably the Minister of Defence, who would be responsible for approving its recommendations, and if necessary obtaining Cabinet authority. The Chairman should have direct access to the Minister of Defence and to the other Ministers concerned. The terms of reference of the Committee should be widely drawn to cover all matters of medical policy, including research: but they should not include questions of pay and allowances. The Committee should submit an annual report to the Minister of Defence.

45. If such a body were established it would necessarily assume many of the functions at present performed by the existing Advisory Boards of the three Services, and the need for them would disappear. It would not, however, be either necessary or desirable for the new body to supplant the National Medical Manpower Committee, which has a specific and limited task which it should continue to discharge.

Status of Medical Directors-General

46. It was proposed by various witnesses, including the British Medical Association, that the three Medical Directors-General of the Services should be members respectively of the Board of Admiralty and the Army and Air Councils. It was urged that this would ensure that medical matters would be fully taken into account whenever they were relevant, and that this is particularly important when mechanised warfare has greatly extended the field in which they are so relevant. It was also stressed that the status of the medical branches would be enhanced. We have not been convinced by these arguments. There is no reason to believe that the present arrangements fail to provide expert medical advice at the highest level whenever it is needed, nor that the Medical Directors-General are at any disadvantage in putting forward their views on any matters which concern their branches. We find it significant that the present Directors-General have informed us that they would not find any practical advantages in the improved status which is proposed. Moreover, the proposal overlooks one consideration which we regard as crucial. The Board of Admiralty and the Army and Air Councils are responsible for the whole organisation and all the operations of their respective Services. The members must therefore be concerned with a very wide range of business, affecting every aspect of the Services, for which each has to accept his share of collective responsibility. To make the

Director-General of Army Medical Services (to use this one instance) a member of the Army Council would place upon him a range of responsibilities far beyond those which he now carries, so that he would have to spend much of his time considering matters entirely unconnected with medicine. The post of Medical Director-General is sufficiently responsible and onerous without seeking to add to its duties, and we conclude that to accept the proposal would be against the interests of the medical branches. A decrease in the efficiency of the medical services would be poor recompense for whatever improvement in status would accrue, and we therefore recommend no change in the present position.

Medical Cadetships

47. A number of witnesses suggested that an increase in the number of regular officers in the medical branches could be secured by granting bursaries to suitable candidates who, in return for the financing of their medical training, would undertake to apply for commissions and to serve for a minimum period. The engineering cadetships provided by the Navy and the Air Force were cited as a comparable case. The (Warren Fisher) Committee on the Medical Branches of the Defence Services of 1933 recommended a limited scheme of this kind, which was in fact adopted and is still in operation, financed by the Service Departments and administered by the Lord Kitchener National Memorial Fund. Five scholarships are offered each year, restricted to sons of service or ex-service men or women. On becoming medically qualified, a scholar is required to apply for a commission and to serve for not less than five years; his parent or guardian is required to execute a bond providing for repayment of the emoluments of the scholarship to the Service Department concerned if this condition is not fulfilled.

48. We consider that there are great objections to an arrangement whereby a minor (or his parent on his behalf) commits himself to a particular career as a means of financing his professional training. For many years the Ministry of Education used to make grants to University students who gave an undertaking to enter the teaching profession, but this system was abandoned in 1951 after it had been generally condemned by educational opinion. We find that opinion in the medical profession (including that of the Deans of medical schools) is generally opposed to its institution for medical students. It should be noted that the engineering cadetships are not on a strictly comparable basis to that envisaged for medical bursaries. The candidate for an engineering cadetship serves for a year in the Navy or the Air Force before he starts his University training and is therefore throughout a serving member of the Forces.

49. Moreover, conditions now are different from those in 1933 in that there has been a very great increase in the assistance provided from public funds for boys and girls who enter the Universities or medical and dental schools. It is, indeed, broadly true that almost any boy or girl who can secure a place at a higher educational institution can receive some assistance from public sources, so that lack of financial means is no longer the main obstacle to higher education and professional training. It is significant that the number of applicants for the existing Kitchener Medical Services Scholarshps is very small, and that even this is usually reduced by the withdrawal of those who win State or Local Education Authority Awards; in some years it is difficult to award the five scholarships which are offered. We do not think that an extension of eligibility, or an increase in the value of the scholarships, would result in any marked increase in the number of suitable candidates.

50. A scheme of financial assistance for medical students who undertake to serve in the Forces has been adopted in Canada, and we understand that it is working satisfactorily. No assistance is given until the student is in his second year of medical studies. In Canada, however, very few students receive State assistance and this may well account for the attractiveness of the scheme. In the light of these various considerations, we do not recommend the establishment of any scheme of bursaries for the medical training of recruits to the Services.

Women Doctors

51. In their evidence before us, the British Medical Association stated that there is scope for the employment of more women doctors in the Armed Forces, and made some specific suggestions. As well as obtaining the views of the Service Departments, we received written and oral evidence from the Medical Women's Federation, who have given careful thought to the issues involved.

52. Only a small number of women doctors are now employed in the Armed Forces. At the end of 1954 there were 14 in the Army, 8 in the Air Force and only one in the Navy. The officers in the Army and Air Force cover a wide range of duties and are by no means solely employed in looking after female personnel in the Services. Of the 14 officers in the Army three were senior specialists, two junior specialists, two in administrative posts (one the commanding officer of a hospital) and seven were employed on general medical praotitioner duties.

53. We were assured by the Medical Directors-General of the Army and the Air Force that there would be no difficulty in providing useful employment for considerably larger numbers of women doctors, and that if suitable recruits were forthcoming they would be acceptable. The Medical Women's Federation stressed that war-time experience had demonstrated the wide range of posts, including specialist posts, which could be satisfactorily filled by women medical officers. Conditions in the Navy are such as severely to limit the employment of women medical officers, and the number must remain very small.

54. Neither the Army nor the Navy grant regular commissions to women doctors. The Army grants short service or extended service commissions, with the effect that a woman can be employed up to the appropriate retiring age but without securing a regular commission. Women doctors have the same pay and conditions as men, including rates of retired pay and gratuity, but the withholding of regular commissions prevents promotion above the rank of Major. The Air Force grants regular commissions to women and the bar to promotion does not therefore exist. We find it difficult to justify the present distinction between men and women medical officers in the Army. Moreover, the Army are unlikely to recruit women medical officers of suitable quality unless the prospects of a satisfactory professional career in the Service are in all respects as good as those in civilian life. We recognise that the grant of regular commissions to women doctors would involve some administrative difficulties, but we do not regard these as insuperable. We therefore recommend that women medical officers should be eligible for regular commissions in the Royal Army Medical Corps, the present bar to promotion thereby being removed.

55. The Medical Women's Federation suggested to us that conscription for national service should be extended to women doctors. They pointed out that this would be one way of meeting a shortage of medical officers in the Armed Forces. They were influenced in this view by their knowledge of the difficult conditions in the medical branches immediately after the war,

when the Central Medical War Committee and the National Medical Manpower Committee which succeded it (both of which Committees had women members) sponsored appeals to women doctors to take short service commissions. The needs of the Armed Forces were not, however, the main consideration. The Federation placed greater stress on the equal status of men and women which is an outstanding feature of the medical profession. It was in the medical profession that equal remuneration was first established, through the National Insurance Act, 1911, and men and women doctors now have equal status in every respect. It was therefore contended that women doctors should accept the same responsibilities as men, and that these should include liability to conscription for national service. It was pointed out that young men who are medically qualified can continue the practice of their profession while they are discharging their obligation for national service, and that there was no justification for treating young women doctors differently from young men.

56. We are unable to accept these contentions. So far as the needs of the Services are concerned, we have shown elsewhere (paragraphs 9–12) that there is no shortage in those categories which are filled by national service officers: the need is for larger numbers of officers holding regular or short service commissions. An increase in the number of conscripted medical officers on national service commissions would therefore do little or nothing to meet the essential needs of the Services. We recognise the importance of the principle of equal status between the sexes in the medical profession. But we would point out that conscription for national service could not be applied to women doctors on exactly the same conditions as for men; there would, for example, have to be many more exemptions for women than are allowed for men on personal grounds, such as marriage. The overwhelming consideration, however, is that the principle of equality in the medical profession must be overridden by the principle of equality of treatment for all women. National service is a liability which is imposed on all young men, and it is therefore proper that it should apply to those of them who are medically qualified. No women are subject to conscription, and we could not recommend that one small group of women should be singled out for a liability which does not apply to any others.

57. The contribution which women doctors could make to the needs of the Armed Forces lies in their taking short service or regular commissions. If our various recommendations, designed to improve the professional opportunities and to provide better pay and conditions in the Services are adopted we should hope that more women would wish to seek a career in the Services. We suggest that any attempts to increase recruitment by such means as lectures to students in the medical schools should be directed towards the recruitment of women as well as of men.

III. PROFESSIONAL

58. Among the many reasons which have been given to us by witnesses for the lack of attraction to doctors of a career in the medical branches of the Armed Forces it is clear that the most cogent is the lack of professional opportunities. We are well aware of the present difficult conditions of Service life, and recognise that many doctors do not regard the financial prospects of a Service career as adequate compensation for these, but even if such difficulties were largely removed, a Service career would still be unattractive unless active steps are taken to improve the professional opportunities open to a doctor who undertakes it. Indeed, a doctor might well be deterred from applying for even a short service commission by the

general belief in the medical profession that the type of experience gained in the Services may not help him in obtaining subsequently a civil appointment.

59. It should be borne in mind that a young doctor on leaving his medical school for the first time experiences some disillusionment in that medicine, as practised in the world outside his teaching hospital, seems to him to fall short of his ideals. Under the present arrangements for national service, most young medical men receive this disillusionment while doing their service, and may consequently attribute it, to a greater extent than is justified, to conditions in the medical branches of the Armed Forces.

60. We realise that the scope of clinical work in the medical branches must of necessity be more limited than in civilian practice. The population to be cared for is predominantly young and healthy, belonging to limited age groups and including comparatively few women and children. On the other hand, preventive medicine—especially in stations overseas and in tropical countries—assumes a greater importance in the Armed Forces than in civil life, yet this is little attraction to recently-qualified doctors whose inclinations are strongly in the direction of trying to heal the sick. Medical undergraduates in this country do not constantly have their interests directed towards preventive medicine; but even if more time and attention were devoted in medical schools to the subjects of hygiene, public health and preventive medicine, the natural interests of students would still be to put first the sick patient.

61. There are other factors which limit the attractiveness of a career in the medical branches of the Armed Forces. There is relatively little scope for undertaking research, or for the younger medical officer to share in this experience. Again, there is a sense of isolation from the main stream of the profession, and in particular from contact with clinicians of outstanding ability. A Service career is much shorter than in civil life, where a doctor in general practice or in the hospital service can look forward to devoting his time and energies to the care of patients at least up to the age of 65 and often longer. In the medical branches of the Forces an officer retires 8 to 10 years earlier. What is much more serious, however, is that a medical officer may quite possibly lose touch with clinical work after reaching the rank of Major in his early thirties, unless he specialises, and even a specialist may, in the interests of his career, have to abandon his professional work in order to do administration on promotion to Lieutenant-Colonel in his early forties. We do not underrate the necessity and importance of medical administration in the Forces, particularly in preparing and training for war, but medical officers engaged on administration have more high ranking posts open to them than are available to those engaged on clinical work. This state of affairs seems to show that greater importance is attached by the Service authorities to administrative than to clinical work; at least, this is the impression gained by the medical profession generally. It is therefore not surprising that the recruitment of doctors fails to come up to expectations.

62. Thus it is a matter of the first importance that the Service Departments should direct their attention to raising the professional standing of their medical branches and should increase the scope of the professional work available to medical officers. Partially successful efforts have been made to that end, particularly since the Warren Fisher Report in 1933, but this process should be materially accelerated.

Specialist Medical Officers

63. In what follows we use the term "specialist" to denote a "senior specialist" in the Navy and Army and a "recognised specialist" in the Air Force. (See paragraph 67.)

Although specialists and those in training to become specialists in the Services form only a quarter of the total number of medical officers, the professional standing and clinical efficiency of each medical branch depends in large measure on them. In the Army, there are 65 hospitals with 13,000 beds, in the Air Force 18 hospitals with 5,000 beds, and in the Navy 7 hospitals with 1,750 beds. The clinical work in these hospitals is in the main done by specialists, with the assistance of those in training; of the latter the more experienced are, in the Army and Navy, called "junior specialists". In addition to these hospital posts, specialists are employed in teaching, in research and in laboratories. The Army and Air Force, as has been seen, are acutely short of specialists. This results in the main from the shortage of regular medical officers, from whose ranks most specialists must of necessity be drawn, but is due in part to what we must regard as the unsatisfactory prospects offered to medical officers who might have the ability and energy to become specialists. Indeed, the prospects are so poor that the Army, whose officers are allowed to retire prematurely if they wish, have lost a number of their specialists who have sought and obtained civil appointments at home or abroad, while still comparatively young.

64. While it does not apply with equal force to all three Services, the general position is that the prospects of specialists, if they remain on their specialised work, are considerably poorer than those of non-specialist officers engaged on medical administration. As a result specialists, if they are not to forego advancement in the Service, have to abandon specialist work, often in their early forties, so as to undertake office jobs. In the "minor" specialities such as oto-rhino-laryngology, gynaecology, anaesthesia, ophthalmology, etc., the Army offer only one post of Lieutenant-Colonel in each speciality and all the other specialists in these departments are Majors. There are grounds which are referred to in paragraph 66 below for treating the Navy differently in this matter and the following recommendation (paragraph 65) applies only to the other two Services.

65. We consider the position in the Army and Air Force in the matter of prospects of specialists cannot be defended. Not only does it lower the prestige of the medical branches in the eyes of the profession, but it is an active deterrent to any doctor with ambitions to specialise who might consider a permanent career in the medical branches, and it may be extremely wasteful of professional abilities and training. In civil life, a doctor who becomes a clinical specialist remains one for the rest of his career and his standing in the profession advances with greater experience. We recommend the application of this principle to the Army and Air Force medical branches. That is to say, there should be a separate specialist section in which the career prospects should be at least as good as the prospects in what might be called the general duty and administrative section. A specialist should look forward to continuing in his specialist work for the whole of his career and, as he gains experience, he should be promoted and, before retirement, reach the rank of at least Colonel or Group Captain. Promotion would then be related, not to "responsibility" in the sense in which the term is used in the Services, but to professional achievements and competence. Our proposals for carrying out this reform and details of pay changes consequent on them are dealt with in paragraphs 112–121.

66. The medical branch of the Navy is much smaller than that either of the Army or of the Air Force, and consequently there is less scope for a clear-cut separation of function between a general duty and administrative section on the one hand and a specialist section on the other. Moreover, naval medical officers are often afloat and out of touch with the hospital services,

and thus have a more varied responsibility than their colleagues ashore. Furthermore, naval clinical specialists are required to serve from time to time in ships where they cannot practise their speciality. In these circumstances we do not think it would be appropriate to introduce any separate specialist section into the Navy. Nevertheless we attach importance to ensuring that the time spent at sea by specialists on general duty work is reduced to the essential minimum, and that specialists promoted to Surgeon Captain should have the maximum opportunity of continuing to exercise their specialist knowledge and abilities, and we recommend accordingly. (Paragraphs 131–133.)

67. If the careers of specialists in all three Services are to be so improved, it is essential that the present standard of medical officers employed in specialist work should be raised, and that no medical officer should be appointed a specialist unless he has sufficient experience, ability and qualifications. At present there are differing standards laid down in each Service. The Army require a specialist to have been qualified for at least seven years, to have had at least five years' experience in the speciality, and to have obtained an appropriate higher qualification. The Air Force also require an appropriate higher qualification and stipulate that the medical officer should have been qualified for at least five years, and should have had at least three years experience in the speciality. The Navy, while requiring the same periods of qualification and experience in the speciality as do the Army, do not insist on a higher qualification. Thus it is clear that the present system of classification varies considerably in each of the three Services. In our view, the standards laid down for specialists by the Army are the minimum which should be accepted and we recommend that the Navy and the Air Force re-examine their requirements and bring them, within a reasonable period, into conformity with these standards. It has already been remarked that the Army and the Navy, though not the Air Force, grade certain of their trainee specialists as " junior specialists ". They are required to have been qualified for at least three years and to have had at least two years' experience in their speciality. It seems to us that it would be more appropriate and in keeping with professional practice elsewhere to refer to these doctors as " senior trainee specialists ".

68. The Service Departments should invariably arrange that medical officers in training to become specialists undertake an adequate period of secondment, on study leave terms, to posts in an appropriate civilian teaching hospital. This secondment should be an essential feature of the training of specialists.

69. We suggest that a candidate for recognition as a specialist, in addition to possessing all the specified requirements, should have to satisfy a special selection board consisting of at least two Service specialists and a leading civilian consultant. The presence of a civilian consultant would provide the board with a wider experience of the speciality than could be found within a Forces medical branch alone. Moreover, it would enhance the general reputation of the specialists, and therefore of the Services, in the eyes of the profession.

70. We attach great importance to bringing the medical branches of the Armed Forces into much closer association with the civilian profession, so that the Service specialist will have better opportunities throughout his career of gaining access to the clinical material he requires for keeping himself up to date; moreover the presence of Service specialists in civilian hospitals and at courses and conferences would do much to break down the feeling amongst young doctors that the medical branches of the Armed Forces provide little scope for a keen clinician.

71. Since the professional value of a specialist can only he increased hy widening his knowledge and experience in treating a great variety of cases (and in many specialities, the Services, even if families of women and children are included, cannot provide the requisite variety and range of work) there must be the fullest co-operation in hoth directions between the civilian hospitals, at home and abroad, and the Service hospitals. Whenever beds are vacant in Service hospitals, they should he made availahle for civilian patients, not necessarily connected with the Services. Although the individual patient must retain his personal choice, we do not helieve that there would he any general refusal hy civilian patients at home to enter Service hospitals, provided it is generally recognised that the Service specialists are properly qualified and possess adequate experience. We understand that corresponding arrangements with civilian hospital authorities are often in force in stations ahroad, and we hope that such co-operation will he developed as much as possible. At the same time we recommend that Service specialists should be seconded much more often than at present to National Health Service hospitals hoth for their own sake, especially after a tour of duty overseas, and to supplement the medical staff at the disposal of Regional Hospital Boards and Boards of Governors of Teaching Hospitals. Again, Service specialists should he encouraged and given opportunities to attend civilian medical conferences and other professional activities. Each Service should make more use of its panel of civilian consultants for advice and assistance and, wherever feasible, regular visits to Service hospitals should he paid by such consultants.

72. We have already mentioned (paragraph 61) the view that greater attention should he paid to research in the Services and that junior medical officers, especially those with a leaning in this direction, should he encouraged and given a chance to help in this work.

73. National service medical officers normally enter the Services from twelve to fifteen months after qualification. The Services would he greatly benefited if arrangements could he made for some of these young doctors, especially those who are anxious to specialise later on, to he given longer deferment and so be called up later. Such men would he more experienced, and might have ohtained a higher qualification and would therefore he of greater assistance to the specialist section of the Services.

General Duty and Administrative Medical Officers

74. Specialists and those in training to become specialists form, as has already been noted, only a quarter of the total strength of medical officers. Of the remaining three-quarters, a large number are employed in ships, units and stations, on what could be described as general practitioner duties. A high proportion of these officers at present hold national service and short service commissions, and their career in the Services rarely exceeds four years. The remainder of the non-specialist officers, mainly regulars, fill a variety of medical administrative posts on the staff, at training schools, and as officers commanding hospitals.

75. It has been represented to us that a doctor who makes his career in the Services and has no desire to specialise must inevitahly lose contact with patients at an early stage and spend most of his career in office johs. Furthermore, it has heen said that even when he is acting as a medical officer in a ship, unit or station, he has limited opportunities of treating any hut trivial ailments, since his patients have to he sent to hospital, and that much of his time is spent in carrying out routine medical examinations of fit and healthy men.

76. We are satisfied that these limitations of clinical scope do exist, and we now make certain proposals to improve the situation. General duty medical officers should be actively encouraged and arrangements made for them to attend nearby hospitals, either Service or civilian, and to undertake regular part-time duties there. We believe that civilian hospitals would welcome this assistance from the Services, for many Regional Hospital Boards are finding difficulty in recruiting junior hospital medical staff. There would be the additional advantage that the medical officer would often be able to share in the treatment of some of the patients he had sent into hospital.

77. All regular and short service medical officers would benefit by fairly frequent attendance at short refresher courses run under the auspices of the National Health Service, and these should become a normal part of their Service medical life.

78. Junior medical officers would be greatly encouraged if they had more clinical work to do and if the Service medical authorities not only recognised this but consistently showed by their attitude towards those engaged on clinical work that they rated such work more highly than that of medical administration.

79. At the same time it must be emphasised that a primary task of the medical branches of the Armed Forces lies in the field of preventive medicine, hygiene and public health; and that it is a matter of the utmost importance that Service personnel should be kept fit at all times for their duties. Thus the inspection of living quarters, messes, cookhouses, latrines, workshops and the like, and frequent medical examinations of personnel are not unimportant matters. Having accepted this doctrine, we aim to bring it home to junior medical officers with greater force than has hitherto been done, by associating with this work all medical officers in the general duty and administrative section. With this object it should become an accepted aim that regular medical officers other than clinical specialists should work for and obtain a Diploma in Public Health or equivalent qualification. Medical officers with this qualification should not be regarded as clinical specialists, but we propose (paragraph 111) that an allowance should be paid to any general duty or administrative medical officer below the rank of Colonel who obtains this qualification in recognition of his having done so.

80. In spite of the fact that much administrative work, especially in the field of preventive medicine, must be done by medical officers, it should be possible to go some length in replacing qualified men, particularly in junior administrative posts, by officers without a medical qualification. For example, in the Army, a large number of Deputy Assistant Director of Medical Services' posts are, owing to the shortage of medical officers, filled by non-medical officers. We think that this should be made permanent and even further extended. If this were done it should be possible to allow more regular Majors of the Royal Army Medical Corps to be employed on medical duties to the advantage both of the officer and of the unit or formation. In the Air Force, there are already posts on stations for Squadron Leaders, and in the Navy, general duty Surgeon Lieutenant-Commanders serve in ships and shore establishments. It should be the aim of the Service Departments to reduce the number of medical officers employed in purely office jobs to a minimum and to increase the time that non-specialist medical officers spend in touch with patients.

General

81. We believe that the various measures we have advocated will do much to improve the standing of the Forces medical branches in the eyes of the profession generally, and will not only add to the attraction of a Service

career, but will raise the standard of efficiency in those branches. Where some of the measures we recommend are, to an extent, already in operation, we advocate a wider and more intensive application of them.

82. We trust that the new machinery we have already recommended (paragraph 44) will ensure closer and more effective working between the National Health Service and the medical branches of the Forces, and will thus provide the Service medical authorities with a means of raising the professional opportunities and standards of the services for which they are responsible.

IV. SERVICE CONDITIONS

83. Many of the serving officers who appeared before us laid great stress on certain non-professional elements in Service life which act as strong deterrents to doctors against a career in the Services. The evidence provided by the Social Survey Division of the Central Office of Information also brought out very strongly this aspect of the problem. Some of the features which were mentioned, such as the need to serve overseas, are inseparable incidents of a Service career, and it must be accepted that the field from which medical officers can be recruited will always thereby be limited. There are, however, certain matters which appear to have a disproportionate influence, not only in restrioting recruitment but also in causing dissatisfaction among medical officers actually serving in the Forces, and in which we believe that improvements could be effected. These comprise three main items:—(*a*) the frequency and uncertainty of postings; (*b*) the difficulties of securing accommodation for married officers; (*c*) the difficulties of providing for suitable education for children.

Postings

84. In the investigation conducted for us by the Social Survey Division the unsettled life of a medical officer, with frequency of postings and the consequent disruption of married life, appeared as the most common reason why national service medical officers did not apply for regular or short service commissions. The actual figures are interesting: 59 per cent. of the officers who had served in the Army gave this as a reason*, with 52 per cent. of those who had served in the Air Force and 42 per cent. in the Navy. For the Army and Air Force it was the most important single reason given, more important than the alleged low standard of Service medicine and lack of opportunity for professional advancement: for the Navy it took second place to the limited scope of clinical work, probably a reflection of the different type of young man who is attracted to the Navy for his national service as compared with the other two Services. We must repeat that some unsettlement is a necessary part of the life of a Service medical officer, who must be prepared to accept overseas postings and also movement within the United Kingdom; this should be borne in mind in interpreting the results of the enquiry conducted by the Social Survey.

85. The extent of overseas postings must be determined by operational needs. The normal praotice of the Army, for example, is that an officer serves three years at home and three years overseas, but the present shortage of medical officers means that for many the period of service at home has had to be reduced to two years. We hope that an increase in the number of regular and short service medical officers will help the Army to revert to

* The doctors who completed the questionnaire were asked to state the reasons for their not applying for regular or short service commissions, without being given any indications of possible reasons. The average number of reasons given by those who had served in tbe Army was 2·7, by those in the Air Force 2·6 and by those in the Navy 2·4.

their normal practice. In the Navy, an officer will normally spend about 60 per cent. of his service at home, 25 per cent. at sea and about 15 per cent. at a shore station abroad. In the Air Force, there is less need for overseas service, and the amount varies with rank and, to lesser degree, character of appointment; Squadron Leaders and Flight Lieutenants, for example, have one tour of 2½ years abroad followed by 7 years at home: Wing Commanders have 5½ years at home after an overseas tour of 2½ years: clinical specialists of the rank of Group Captain and above normally have no overseas service, whereas Air Vice-Marshals on general duties or with staff appointments have alternate tours at home and overseas. We do not feel called upon to comment on these arrangements. What is relevant and important, however, is that we have had evidence of much uncertainty for the individual officer about the timing and place of his posting even when, it has been alleged, the particular medical department has been in a position to remove that uncertainty. Although it appears that the general system of postings is sound, it also seems undoubted that lapses occur, and the evidence we have had suggests that they are too frequent to be regarded with equanimity. We therefore urge that every effort should be made to give the medical officer adequate warning of his overseas postings. It should be appreciated that unless the individual officer knows where his precise station will be well before he leaves the United Kingdom, it may be impossible for him to make arrangements for his family to accompany him. We are aware that this is a matter which has been engaging the attention of the War Office for all Army officers and troops: we would urge its special importance for medical officers in all three Services, as a matter requiring improvement even if changes in the systems of posting are necessary.

86. Although operational requirements must also dictate changes of posting in the United Kingdom and during a tour abroad, we are not satisfied that everything that could be done is in fact done to minimise what is an undoubted feeling among medical officers that they are moved about in an apparently casual and haphazard way, with the result that their opportunities of linking up with their families and remaining with them for a reasonable length of time are meagre. The needs of the Services should not normally require frequent and unexpected moves in the United Kingdom or during a tour abroad. We therefore recommend that medical officers should normally be posted to particular appointments for not less than three years, so that when an officer is moved, he should have a reasonable expectation of staying in his new post for at least that period of time. This should be regarded as a minimum, to be varied only in exceptional circumstances. For many medical officers, particularly specialists, it should be possible to provide a security of tenure which approximates to that which they could obtain in civilian life. We regard this as important not merely because of its effect on the individual officer and on recruitment, but also because it is necessary for the maintenance of high standards of clinical medicine. Again, we would stress the importance of adequate warning of a new posting, with every effort made to meet the personal convenience of the officer concerned.

Accommodation for Married Officers

87. The shortage of accommodation for married officers, both in the United Kingdom and overseas, is a general problem, and not confined to medical officers. The position differs greatly in different places, but the situation is generally serious in spite of great efforts on the part of the Services. We hope that measures now contemplated and in hand by the Service Departments will lead to amelioration. There is, however, one matter of particular importance, and that is that the medical officer suffers from a special disadvantage as compared with his combatant colleagues. This arises simply

because of his period of professional training before he enters the Services, which results in his being older than other officers when he starts his Service career. Not only is he, therefore, more likely to be married at the start of his career, but also he is at a disadvantage because married quarters are normally allocated on a points system in which length of service is an important element. The result is that the medical officer is usually at a permanent disadvantage as compared with other officers. An example was cited to us of two officers aged 28, an infantry Captain and a medical officer of the same rank; the infantry officer would have 30 points whereas the medical officer would have only 12, solely because of their diffcrent ages of entry. We find it difficult to justify this discrimination, adventitious though it may be, and therefore recommend that the rules for the allocation of married quarters should be revised so as to place medical officers on an equal footing with combatant officers of the same age and rank.

Children's Education

88. The difficulties of providing for the suitable education of children again constitute a problem which is not confined to medical officers, and one which has engaged the attention of the Service Departments generally in recent years. They arise, of course, from the movements of the officer in the course of his career, especially during the years when his children are of school age. For the majority of officers there is posed the difficult choice of either attempting to provide boarding school education for their children or accepting separation from their wives, who remain with their children to provide a settled home from which continuous attendance at one day school is possible. Provision of boarding school education is usually financially impossible unless the parents have private resources apart from the officer's pay and allowances. The problem arises in a specially acute form when the officer is serving overseas; but it also exists in this country, in that not only are frequent changes of school undesirable but also it can never be certain that grammar school places will be available in the area to which the officer is posted. Less frequent posting would therefore help to give some relief; but the essential problem would remain.

89. The matter was discussed by a Select Committee of the House of Commons on the Army Act and the Air Force Act, which published a Report (House of Commons Paper No. 223) in August, 1954. The Committee urged that the central and local education authorities should increase their efforts to provide educational facilities and grants for the children of men serving in the Forces, and recommended that suitable legislation should be introduced as soon as possible. The Service Departments and the Ministry of Education, however, saw certain difficulties in giving statutory rights to servicemen in this regard. The matter was raised again in the Eighth Report (House of Commons Paper No. 291) from the Select Committee on Estimates in November, 1954. As we were aware that it was under consideration by Ministers, in December last our Chairman addressed a letter to the Minister of Defence pointing out that the difficulty in providing education for their children was a major deterrent to professional men in making their career in the Services, and an outstanding cause of dissatisfaction amongst those already serving on permanent commissions.

90. We recognise that, as this problem is not confined to medical officers, it would not be possible to introduce measures to meet it which were limited in their application to what is in fact a relatively small class, which would thereby be placed in a particularly privileged position. Nevertheless we regard it as so important for the medical officer, and therefore for the organisation of the medical branches of the Forces as we envisage that they should

develop in the future, that we are bound to support as the most certain and practicable solution the proposal which has been advanced on various occasions for the payment of educational allowances in respect of children maintained at boarding schools. Allowances of this kind are already made to officers in the Foreign Service, as well as to officers of the Home Civil Service who are posted overseas. The problem is not confined to officers who happen to be serving overseas. A tour of overseas duty normally lasts three years, in some cases less, and the officer would usually not wish to maintain his children at boarding schools while he was overseas and transfer them to day schools when he is in this country, even supposing that suitable day schools were available; on educational grounds it would be undesirable for him to do so. Moreover, the problems of providing suitable education also arise for certain officers stationed in this country, if they are in remote places and liable to changes of posting. We would therefore wish to provide the educational allowance to all medical officers, whether stationed at home or overseas.

91. Education at a boarding school is often necessary because of the lack of places at suitable day schools. This is a matter in which we think that improvement should be possible, and we suggest that the co-operation of Local Authorities and of direct grant schools should be sought in the provision of school places for the children of medical officers and other Service personnel. We are aware that there are many administrative difficulties, but we are not convinced that they are insuperable. We have considered the possibility that the Services should establish their own schools for the children of serving officers. This is already done in certain overseas stations, the most outstanding instance being in Germany. In many cases, however, the numbers of children are too small to make this a desirable or practical proposition, particularly for secondary education. Even were this not so, we should regard the provision of specific educational facilities in this country as a retrograde step and consider it as better, and less costly, to make appropriate arrangements within the existing educational system. Certain difficulties also arise in the provision of grants from Local Authorities for the higher education of the children of Service parents, because of the lack of the necessary residential qualifications. Again we consider that these must and can be overcome.

V. PAY AND PROSPECTS*

Introduction

92. It was abundantly clear from the evidence put before us that the main causes of the difficulties now being experienced in recruiting regular medical officers for the Services are professional and social. There was little, if any, suggestion that pay, prospects and other related conditions of service were of primary importance in the minds of national service and short service officers in deciding against a Service career. In most cases, however, those who gave evidence seemed never to have given serious thought to these matters and it would not necessarily be right to assume that had they done so they would have been satisfied. Serving regular officers, and particularly those who were specialists, criticised their terms of employment with varying degrees of intensity and had the support of the British Medical Association. In view of these circumstances we have undertaken a general survey of the terms of service, especially pay and prospects, of national service, short service and regular medical officers. It is necessary in this relation to have regard on the one hand to the remuneration of the

* Attention is drawn to the Supplementary Note on page 56.

medical profession in this country and on the other hand to that of officers in other branches or arms of the Services. Regard must also be had to the pay standards obtaining in the Colonial Medical Service. It will be seen (paragraphs 3 and 4) that we have been at pains to inform ourselves as regards the facts on which such comparisons must be based, but we feel bound to point out that the comparisons are inevitably somewhat speculative because of the very different circumstances in which those concerned live and work. We have, in addition, brought into consideration the fact that while there has been a substantial improvement in the recruitment of regular medical officers since the interim pay increases of 1st October, 1953, were brought into operation, that improvement is not sufficient to offset in the near future the existing recruitment backlog. We have also taken note of the fact that in the Army, where, as in the Air Force, the shortage of specialists is serious, the wastage of medical officers by voluntary retirement continues to be severe. Our general conclusion is that further increases in pay are warranted and necessary in the case of all ranks from Major to Brigadier, that the pay of specialist Colonels and Brigadiers should be improved relatively to that of general duty and administrative Colonels and Brigadiers, and that the ranking of certain specialists' posts should be reviewed. What has been said above applies in general to Air Force medical officers as well as to Army medical officers but only with certain major reservations to naval medical officers.

93. We pass now to our detailed proposals in regard to the remuneration of Service medical officers. They are based on enquiries which have been spread over eighteen months and on our assessment of the position as it obtained in the early summer of this year. We suggest that the increases in pay which we propose should take effect from 1st July, 1955.

Pay and Promotion

94. A medical officer's pay depends on his rank, the scale of pay of his rank and the number of years he has served in that rank. It follows that in considering the question of remuneration regard must be had to his prospects of advancement from rank to rank and that questions of pay and promotion must be dealt with together.

95. Different considerations apply at different rank levels and it is necessary to deal with the question of remuneration under three headings:—

(A) Lieutenants and Captains.

(B) Majors, Lieutenant-Colonels and Colonels.

(C) Brigadiers and Major-Generals.

(A) Lieutenants and Captains

96. The information given in the paragraphs that follow in regard to Army medical officers applies to medical officers of comparable rank in the Navy and the Air Force.

Promotion

97. A Lieutenant is automatically advanced to the rank of Captain after one year's service and to that of Major after eight years' service. A medical officer is normally recruited at age 25 and in that event is promoted to be Captain at age 26 and to be Major at age 33. This applies to national service and short service officers as well as to regular officers except that, owing to the short length of their service, officers in the two former groups do not normally qualify for appointment as Majors. We propose no alterations in these arrangements.

Emoluments

98. *Regular Officers.*

ANNUAL EMOLUMENTS ASSUMING ENTRY AT AGE 25

	Pay	Ration Allowance (grossed for tax)*	Marriage Allowance	Total
	£	£	£	£
Lieutenants				
Age 25	484	128	338	950
Captain				
Age 26	593	128	338	1,059
27	593	128	338	1,059
28	648	128	338	1,114
29	693	128	338	1,159
30	821	128	338	1,287
31	821	128	338	1,287
32	876	128	338	1,342

* *Note:* The actual rate of ration allowance on 31st March, 1955 was 4s. 6d. per day (£82 per annum). It is not taxable, however, and in order to reflect its real value it is necessary to " gross it for tax ". £128 is the gross sum which would be reduced to £82 after deduction at the standard rate of tax for 1955–56.

99. Regular officers are entitled, in addition, to a Permanent Commission Grant of £1,500 (taxable) on completion of one year's satisfactory service as a medical officer. The net value of this grant varies with the circumstances of each case but is, in general, found to be of the order of £900.

100. These emoluments are better than those of the corresponding age group in the National Health Service and were recognised to be so by those in that age group whom we interviewed or who communicated with us in writing. They are also better than those of combatant officers of similar standing. We do not regard as necessary or justifiable any improvement in pay rates for these ranks.

101. *Short Service Officers.* The emoluments of these officers are in general the same as those of regular officers. They are not, of course, entitled to the Permanent Commission Grant of £1,500 (taxable) referred to above. They are, on the other hand, entitled to a non-taxable gratuity of £150 for each completed year of service. Here, as in the case of regular officers and for the same reasons, we regard the existing remuneration as generally satisfactory. There is one direction, however, in which it requires review. The great majority of short service medical officers are recruited from the National Health Service and return to it on completing their service on the active list. It is important from their point of view that the time so spent should be reckonable for the purposes of the superannuation allowance to which they will become entitled when they eventually retire from the National Health Service. In the case of a medical officer whose short service commission is one of four years or longer, this can be secured only if the individual concerned contributes to the National Health Service Superannuation Fund both the National Health Service employee's (6 per cent.) and the employer's (8 per cent.) contributions (based on his notional earnings in the National Health Service for the whole period). The amount involved varies with the circumstances but in the case of a typical four-year commission would amount to about £400. The gratuity payable to the medical officer, viz., £600 (£150 × 4) on completion of his commission,

would thus be subject to a deduction of £400, leaving a balance of only £200. If the commission is for three years only, the employer's contribution is, under existing regulations, paid by the National Health Service employing authority. It results that if the medical officer referred to above had opted for a three-year commission he would have had to refund only £120 instead of £400. The man who undertakes a four-year commission is thus at a serious disadvantage since the net gratuity payable to him is £200 whereas, in the case of one who serves for three years only, the net gratuity is £330 (£150 × 3 − £120). This anomaly is the more marked when regard is had to the fact that service rendered during the fourth year is obviously more valuable than that given during the first and second, when the medical officer is still inexperienced, and even during the third year of service. In our view, the arrangement under which a short service officer of four or more years' service is required, in the circumstances referred to above, to contribute to the National Health Service Superannuation Fund both the employer's and the employee's contribution, is inequitable and we are of the opinion that the employer's contribution should be defrayed from Service funds. The result would be that a medical officer with a four-year commission would have to contribute, not £400 but about £175 to the Fund, leaving a balance of £425.

102. *National Service Officers.* The annual emoluments of national service medical officers, particularly in the first 18 months of their 24 months' service, are less than those of regular and short service officers. The figures given below assume that entry is on the 25th birthday of the man concerned.

	Rate of Pay	Ration Allowance (grossed for tax)	Marriage Allowance	Total Emoluments
	£	£	£	£
Age 25 (Lieutenant)				
National service	401	128	228	757
Regular and short service ...	484	128	338	950
Age 26—*first six months* (Captain)				
National service	511	128	228	866
Regular and short service ...	593	128	338	1,059
Age 26—*second six months* (Captain)				
National service	593	128	228	949
Regular and short service ...	953	128	338	1,059

103. Many of the national service medical officers whom we interviewed expressed dissatisfaction at being paid less than regular and short service officers of the same length of service, taking the view that their qualifications and experience being identical with those of their regular and short service colleagues, there could be no justification for remunerating them at a lower rate for doing identical work. Others protested that there was no ground for differentiating between national service and regular and short service medical officers in the case of the marriage allowance especially as they, unlike their regular and short service colleagues, were left to fend for themselves in the matter of obtaining accommodation for their families.

104. These distinctions between the terms of service of regular and short service medical officers on the one hand and their national service colleagues on the other undoubtedly give rise to resentment and tend to provoke enduring ill-will against the Services in the minds of many of the younger members of the medical profession. They obtain, however, in all branches of

the three Services and the first point we had to consider was whether a case could be made out for treating medical officers exceptionally in the matter of pay. We found ourselves unable to make a recommendation to this effect partly because we felt that, as compared with other national service officers, they are already at an advantage in that they obtain an immediate commission and pursue their civilian profession during their two years' national service, so acquiring experience which is of value to them later in their careers, and partly because, in so far as they have a grievance, they have the easy remedy of applying for a three-year short service commission, with the advantages which go with it, in lieu of a national service commission—a remedy which is not open to most other national service officers.

105. The position in regard to marriage allowance is different. Marriage allowances at the full rate are payable to officers of 25 years of age and over. In the case of regular and short service officers the full rate is £338 per annum. In the case of national service officers it is £228 per annum. This differentiation seems to us unjustifiable. Most national service medical officers are married and at least 25 years of age and there is a widespread sense of grievance amongst them in regard to this matter. We recommend that the allowance be increased to £338 per annum in their case and that they be eligible also for the married unaccompanied rate of local overseas allowance. We appreciate that if this concession be made to national service medical officers it will be difficult to withhold it from other national service officers who are similarly situated. The number of these officers is, however, very small since hardly any national service officers, other than medical officers, are married and over 25 years of age.

(B) Majors, Lieutenant-Colonels and Colonels

106. We propose (paragraph 65) that at this level the general body should be split into two sections—a general duty and administrative section and a specialist section—with separate establishments and different rates of remuneration. We deal in the first instance with the former section, which is much the larger of the two, including as it does about three quarters of the medical officers in both the Army and the Air Force. What follows (paragraphs 107 to 126) does not relate to the Navy, in which the circumstances are fundamentally different and the position in regard to which is dealt with in paragraphs 127–133.

General Duty and Administrative Medical Officers

Promotion

107. Promotion to Lieutenant-Colonel or Wing Commander is, in practice, by qualified seniority, and the aim is so to adjust establishments that it takes place on the average after 9 years' service in the rank of Major and at about age 42 in the Army, and after 7 years in the rank of Squadron Leader and at about age 40 in the Air Force. Promotion to Colonel or Group Captain is by selection. In the Army about 75 per cent. of those eligible obtain it while the remaining 25 per cent. retire in the rank of Lieutenant-Colonel. In the Air Force only about 60 per cent. of those eligible obtain promotion while the remaining 40 per cent. retire in the rank of Wing Commander. The aim at this level is so to adjust establishments that promotion takes place, on the average, after six years' service in the rank of Lieutenant-Colonel and eight years' service in the rank of Wing Commander, at about age 48 in both Services. Promotion to Brigadier or Air Commodore is by selection and is obtained in normal circumstances by about 25 per cent. of Colonels and about 33 per cent. of Group Captains at varying ages, depending on the occurrence of vacancies and the relative merits of individuals.

108. This promotion layout seems to us satisfactory save in one respect, and that is the proportion of Wing Commanders who obtain promotion to Group Captain. We propose that the proportion be increased to 75 per cent.

Emoluments

109. The scales of pay of (i) Majors and Squadron Leaders, of (ii) Lieutenant-Colonels and Wing Commanders and of (iii) Colonels and Group Captains were increased, as an interim measure, on and from 1st October, 1953, by amounts ranging in the case of group (i) from 5s. 0d. to 11s. 0d. per day, in the case of group (ii) from 7s. 0d. to 13s. 0d. per day, and in the case of group (iii) by a flat rate of 10s. 0d. per day. We propose that these scales be now further increased throughout by 5s. 0d. per day in the case of group (i), by 6s. 0d. per day in the case of group (ii), and 7s. 0d. per day in the case of group (iii). There would result overall increases, as compared with the position on 30th September, 1953, of 10s. 0d. to 16s. 0d. per day (£182–292 per annum) in the case of group (i), of 13s. 0d. to 19s. 0d. per day (£237–347 per annum) in the case of group (ii) and of 17s. 0d. per day (£310 per annum) in the case of group (iii).

110. The rates of pay in force before 1st October, 1953, the present rates and the proposed rates of pay of non-specialist medical officers are set out in detail in Appendix IV, which also shows what would be their overall emoluments if our proposals are adopted. The Table relates to the Royal Army Medical Corps but is applicable to the corresponding ranks in the other two medical branches.

111. We have referred elsewhere (paragraph 79) to the desirability of encouraging general duty and administrative medical officers to take a greater interest than hitherto in preventive medicine and we suggest that any medical officer in this section who obtains a Diploma in Public Health or an equivalent qualification, and not being higher in rank than a Lieutenant-Colonel, should be granted an allowance of 4s. 0d. per day (£73 per annum). It is our recommendation that this arrangement should apply in the Navy and Air Force as well as in the Army.

Specialist Medical Officers

112. We come now to the specialist* section and we assume that for the future this section will be separate from the general duty and administrative section from the point of view of pay and promotion in both the Army and the Air Force.

113. There is a further question which must be considered before we outline our proposals in regard to this section. It relates to the system of accelerated promotion for specialists, which at present obtains in the Air Force. Under this arrangement specialists obtain earlier promotion than their general duty and administrative colleagues, i.e., to Squadron Leader at age 31 instead of at age 33, to Wing Commander at age 38 instead of at age 40, and to Group Captain at age 45 instead of at age 48. There is much to be said in principle for this way of recognising the exceptional quality of the work which specialists undertake but the pecuniary effect of so doing is much less than might at first sight be supposed. A specialist, who receives accelerated promotion to Squadron Leader at age 31 and who retires as a Group Captain specialist at age 57, earns in the course of his Service career only about £2,500 more than a general duty or administrative medical officer who also retires as a Group Captain. The Army and the Navy handle the matter in a different way. The specialist in those Services does not receive accelerated promotion but is granted specialist pay from the beginning

* For definition of what is meant by the term " specialist " see paragraph 63.

of his career as a specialist, with the result that at the end of it—assuming he becomes a specialist at age 33 and retires as a Colonel at age 57—he has earned about £4,250 more than his general duty or administrative colleague. As this advantage is spread over 25 years this amount seems to us little enough, and we make proposals elsewhere (paragraphs 118–121) which would result in its increase. It seems to us that it would be difficult so to vary the Air Force system as to ensure a reasonable pecuniary advantage to the specialist and we have reluctantly come to the conclusion that it should be abandoned. Our pay proposals are based on the assumption that our conclusion on this will be accepted.

114. There is a related aspect of this matter which can be more conveniently mentioned here than elsewhere though it refers not to specialists but to those who are endeavouring to fit themselves for appointment as specialists and who may be called trainee specialists. The Army, though not the Air Force, make a practice of granting an allowance of 4s. 0d. per day (£73 per annum), and the Navy 5s. 0d. per day (£91 per annum) to selected trainee specialists of a certain seniority and, as it is highly desirable to encourage medical officers to undergo the rather lengthy period of training which is necessary in preparing to acquire specialist status, we think that this is a wise step to take. The Air Force, on the other hand, treats all trainee specialists alike and pays none of them an allowance. We think that the Air Force would be well advised to adopt the Army and Navy practice of paying selected senior trainee specialists what is, in effect, a retaining allowance, and we so recommend.

115. The rate paid by the Navy in this regard is higher than that paid by the Army because the allowance is payable only when the man concerned is posted for specialist duties and not when he is on a training course, or serving afloat, etc. We refer to this matter again in paragraph 133.

116. The total number of specialists required by the Army is about 450 and the Air Force need about 200. These numbers include all trainee specialists in the case of the Air Force but only allowance-paid trainee specialists in the Army. The number in post is substantially less than the number required by both Services and unfortunately the shortage is primarily amongst the fully qualified and recognised specialists, with a result that the proportion of the latter to trainee specialists is too low. We have assumed for the purposes of our pay proposals that the proportion of specialists to allowance-paid trainee specialists will be increased as circumstances permit to about 60 : 40. It may be that in the course of time an even higher proportion may be attainable so far as the supply of candidates is concerned. In that event it would be necessary to review the situation with the object of ascertaining whether there is a case for carrying a higher proportion of specialists to allowance-paid trainee specialists than 60 : 40.

Promotion

117. We propose that the standard service and age points for promotion should be the same as in the general duty and administrative section (paragraph 107). Individual medical officers in the general duty and administrative section would, however, have to await the occurrence of vacancies in the grade above before they could be promoted, and a proportion of them—about 25 per cent.—would be retired while still Lieutenant-Colonels or Wing Commanders. In the case of a medical officer who has succeeded in establishing himself as a specialist a rather different procedure seems to be warranted. We recommend that in his case, assuming him to be professionally competent and otherwise fit, promotion up to and including the

rank of Colonel or Group Captain should be by service and irrespective of establishment. A new entrant specialist Major would automatically become a Lieutenant-Colonel after 9 years' service in the rank of Major and a Colonel after 6 years' service in the rank of Lieutenant-Colonel. A Squadron Leader specialist would be promoted automatically after 7 years' service in that rank and further promoted after 8 years' service as Wing Commander. A recognised specialist would thus be assured from the outset that, subject to his being professionally competent and otherwise fit, he would be ranked as a Colonel or Group Captain, as the case might be, within a space of 15 years from the date of his appointment as Major or Squadron Leader. Promotion to Brigadier or Air Commodore would depend on the occurrence of vacancies and would be on a selective basis.

Emoluments

118. Specialist Majors and Lieutenant-Colonels at present receive an allowance of 12s. 0d. per day (£219 per annum) over and above the emoluments of general duty or administrative Majors and Lieutenant-Colonels of the same standing. We propose the continuance of this arrangement, as a result of which the remuneration of those concerned will be increased by the same amounts as in the case of their general duty and administrative colleagues (paragraph 109). Specialist Colonels, on the other hand, do not receive a specialist allowance but on promotion enter the scale which applies in the case of general duty and administrative Colonels at a rate of pay which is 6s. 0d. per day (£110 per annum) above the minimum of the scale, with a result that they attain to the maximum of that scale after two years instead of after six years. A specialist Colonel, having attained the maximum of the scale, is, however, at no advantage as compared with a general duty or administrative Colonel who has also attained the maximum. We feel that this is not satisfactory and we propose that a specialist Colonel should, throughout his career in that rank, receive a specialist allowance of 12s. 0d. per day (£219 per annum) over and above the emoluments of a general duty or administrative Colonel of similar standing with a result that his pay at the maximum would be increased by 19s. 0d. per day (£347 per annum)* as compared with his pay prior to 1st October, 1953. He should enter the new scale at the minimum which would, however, be 13s. 0d. per day (£237 per annum)* higher than the amount at present payable to a newly promoted specialist Colonel.

119. We recommend the same rates of pay in the case of specialist Squadron Leaders, Wing Commanders and Group Captains respectively.

120. The rates in force before 1st October, 1953, the present and the proposed rates of pay of specialist medical officers are set out in detail in Appendix V, which also shows what would be their overall emoluments if our proposals are adopted. The Table relates to the Royal Army Medical Corps but the rates proposed are applicable to the corresponding ranks in the medical branch of the Air Force also.

121. In the Army, though not in the Air Force, it has been found convenient in the case of certain specialities, e.g., oto-rhino-laryngology, radiology, gynaecology, to select one specialist who, in addition to his other duties, acts as adviser to the War Office on matters affecting his speciality. This medical officer is at present ranked as a Lieutenant-Colonel specialist.

* This amount includes the 7s. 0d. per day increase proposed for all medical officers in the rank of Colonel.

We propose that he be ranked as a Colonel specialist and that he be paid an allowance of 4s. 0d. per day (£73 per annum) in addition to the normal pay and specialist allowance of that rank in recognition of his advisory responsibilities.

(C) Brigadiers and Major-Generals, Air Commodores and Air Vice-Marshals

Promotion

122. Promotion is by selection and no issue arises.

Emoluments

123. Brigadiers and Major-Generals may be administrative or specialist. The pay of all Brigadiers was increased by 13s. 0d. per day (£237 per annum) on 1st October, 1953, and we propose that it be now further increased by 7s. 0d. per day (£128 per annum), making 20s. 0d. per day (£365 per annum) in all. We take the view that, as in the case of Colonel specialists, Brigadier specialists who are at present paid at the same rate as administrative Brigadiers should be granted, in addition, the normal specialist allowance viz., 12s. 0d. per day (£219 per annum). The overall increase as compared with the rates in force before 1st October, 1953, in their cases would thus be 32s. 0d. per day (£584 per annum).

124. The pay of Major-Generals was not increased on 1st October, 1953, nor do we now suggest any increase in the case of administrative Major-Generals. We think, however, that Major-General specialists should draw the normal specialist allowance, viz., 12s. 0d. per day (£219 per annum) in addition to the basic rate of the rank.

125. The standard rate of pay for Major-Generals throughout the Army is £6 per day (£2,190 per annum) or, including marriage allowance and ration allowance grossed for tax, £2,792 per annum. That rate has hitherto been regarded as the ceiling for senior officers below the rank of Lieutenant-General, even where, as in the case of medical officers, the rates payable for ranks up to Brigadier are higher than those of comparable combatant ranks; and we agree that the ceiling should continue to apply to administrative medical officer Major-Generals, whose duties are in essence similar to those of many other Major-Generals. In the case of specialists, however, what we are primarily concerned with is the value to be attached to the professional qualifications of those concerned and the ceiling, if rigidly applied, would cause some specialists to be paid at rates which, in our judgment, are too low and it will be seen from Appendix V that in certain cases we propose rates of pay in excess of £6 per day.

126. Transfer between the sections will not in general be permissible but may from time to time be necessary at this level in the interests of the Service. In any such exceptional case the specialist concerned should, we think, be entitled to retain his existing emoluments if higher than those of the post to which he is transferred.

Application to the Navy

General

127. For reasons that have already been stated (paragraphs 66 and 106), we do not recommend that separate specialist and general duty and administrative sections be set up in the Navy.

(A) Surgeon Lieutenants, Surgeon Lieutenant-Commanders and Surgeon Commanders

Pay and Promotion

128. For medical officers other than specialists and below the rank of Surgeon Captain we see no reason to differentiate in these matters between the Navy and the other two Services and what we have said in earlier paragraphs in regard to the pay and career prospects of Army and Air Force medical officers should be taken, save in one respect set out in the next paragraph, as referring to naval medical officers also except in so far as the context makes it clear that this is not intended.

129. In the Army 75 per cent. of those who attain the rank of Lieutenant-Colonel subsequently become Colonels. In the Air Force 60 per cent. of the Wing Commanders may now expect promotion to Group Captain, and we have recommended elsewhere (paragraph 108) that the establishment should be so adjusted as to permit in future the advancement of 75 per cent. of the Wing Commanders. In the Navy less than 50 per cent. of Surgeon Commanders are promoted and the remainder are, in normal circumstances, retired in that rank at age 55. The Navy seeks to recruit 70 per cent. of its medical officers for permanent employment while the other two Services aim at having 50 per cent. or less in that category. It results that the Navy have to provide careers for a substantially greater proportion of their new entrant medical officers than have the Army and the Air Force. The situation in this regard is of course relieved by the high proportion of retirements at the Surgeon Commander level. On the other hand such retirement is undoubtedly a serious hardship, since it results in retirement two years earlier than might have been expected, and a rate of retired pay of £625 per annum instead of £825 per annum (or £900 per annum after 6 years' service as a Surgeon Captain). The need to review this arrangement, which the Navy has hitherto found to be best adapted to its needs, would be less urgent if our proposal (paragraph 148) for the re-employment in a civil capacity of naval medical officers retired on age grounds were adopted. We fear, however, that the recruiting position will continue to be unsatisfactory so long as the proportion of Surgeon Commanders retired at age 55 is of the order of 50 per cent. and we think that, if experience shows that our fear is well-founded, the Navy should review their practice in this regard.

130. Specialists, as already explained, are in the rank of Surgeon Lieutenant-Commander or Surgeon Commander and we propose the same rates of pay and allowances as we suggest in the case of comparable ranks in the Army and Air Force.

(B) Surgeon Captains and Surgeon Rear-Admirals

131. In the Navy there are no Surgeon Captain specialists and all Surgeon Captains are on a common scale. In those circumstances we suggest that the maximum of the Surgeon Captain's scale be fixed at £5 17s. per day—a rate midway between the proposed maximum of general duty and administrative Colonels and Group captains viz., £5 11s. per day—and the proposed maximum of Specialist Colonels and Group Captains viz., £6 3s. per day. A Surgeon Commander specialist promoted to Surgeon Captain should enter the scale at the point next above his existing rate of pay plus specialist pay.

132. We make no proposals in regard to the emoluments of Surgeon Rear-Admirals. Their duties are primarily administrative.

133. There is one further matter affecting the pay of naval medical officers which it is convenient to mention at this stage. The naval specialist allowance is the same as the Army specialist allowance, viz., 12s. per day, but

is suspended while the officer is not appointed for specialist duties, e.g., when at sea or on a course. It seems to us difficult to defend an arrangement under which a medical officer's remuneration is substantially reduced because circumstances temporarily do not permit of the exercise of his specialised skill, and we think that the practice of suspending his specialist allowance in such circumstances should be discontinued.

Miscellaneous

Ranking of Senior Posts

134. We have not thought it appropriate that we should scrutinise in detail the grading of posts below that of Brigadier and equivalent ranks in the other Services, more particularly as a comprehensive review of those gradings is at present being undertaken by the three Services. We are, however, constrained to make one comment on the gradings as they now exist and that is that, in our view, the standards adopted tend to be if anything too severe in the case of clinical posts and not severe enough in the case of administrative posts. It results that, contrary to professional practice, the clinical medical officer is apt to be less well paid than his administrative colleague.

135. In the case of the Navy we have no proposals to make in regard to the senior posts. We do, however, feel it necessary to suggest some alterations in the case of senior posts in the Army and the Air Force.

Army

136. There are eight posts for Command Consultants. Six of these are in the major Overseas Commands and two in the Royal Army Medical College. Four are in Medicine and four in Surgery. The posts are held by Colonels. The six appointments in the Overseas Commands are the top ranking clinical posts in those Commands and we propose that they be graded as for Brigadier. The two in the Royal Army Medical College are held by the senior assistants to the Directors of Medicine and Surgery respectively and we propose no alteration in their grading.

137. The Directors of Medicine, Surgery, Pathology and Psychiatry are Brigadiers. They are employed for part of their time at the War Office and for part at the Royal Army Medical College. Their duties are thus part administrative and part clinical, a fact which is recognised in their titles, e.g., Director of Medicine and Consulting Physician. The posts of Director of Medicine and of Director of Surgery are, in our view, of outstanding importance and we recommend that they be regraded as for Major-General specialists. The Directors of Pathology and of Psychiatry at the War Office should remain Brigadiers but the present rule whereby specialist Directors may become supernumerary Major-Generals if administrative medical officers junior to them are promoted to Major-General should apply to them.

138. The remaining Director—the Director of Army Health—unlike his colleagues is concerned with preventive as opposed to remedial medicine. We have already expressed the view that preventive medicine, especially in wartime, is of primary importance so far as the Army is concerned (paragraph 79) and we think that fact should be recognised in the grading of the Director of Army Health. We propose that his post, which now ranks as for a Brigadier specialist, should be regraded as for a Major-General specialist.

139. There already exist eight posts for Major-Generals all of which are on the administrative side. The creation of three additional specialist Major-General posts—making 11 in all—would lead to an unbalanced structure if the number of administrative Major-General posts, for which specialists would

no longer be eligible, were left unchanged. The War Office should, therefore, when carrying out the upgrading of the specialist posts, review the number of administrative Major-General posts with a view to making an appropriate reduction.

Air Force

140. There are at present three posts for Air Vice-Marshals in the medical branch of the Air Force, two on the administrative side and one for a specialist. We think that there is justification for increasing that number to five, of which two at least should be posts for specialists. In our proposals for the Army, we have recommended that the posts of Director of Medicine and Director of Surgery should be regraded as for Major-Generals (paragraph 137), on the ground that the holders of these posts necessarily exert an important influence throughout the specialist section of the Royal Army Medical Corps. We can see no *prima facie* reason why the same should not apply to the Air Force, with Air Vice-Marshal posts established for the consultant in medicine and the consultant in surgery. We have, however, had evidence on this matter from the Director-General of Medical Services of the Air Force, who, although stressing the need for an increase in the establishment of higher posts for specialists, is strongly opposed to their being reserved for particular specialities. The practice of the Air Force is to select specialists for promotion to the higher ranks on the basis of their seniority and professional standing, irrespective of the particular fields in which their specialities lie. The Director-General is satisfied that this system best meets the needs of his branch, and that to restrict two of the proposed Air Vice-Marshal posts to specialists in medicine and in surgery would entail serious disadvantages. Although the arguments advanced did not carry conviction with us, we recognise that due weight must be given to the views of the Director-General, based as they are on great experience and intimate knowledge of conditions in the Air Force. We therefore simply record our view that the senior consultants in medicine and surgery in any Service necessarily occupy positions of outstanding importance which should normally be recognised by high rank.

Short Service Commissions

141. Short service commissions were offered by all three Services prior to the outbreak of war. They were for five years in the case of Army medical officers and for three years, extensible on the application of the individuals concerned to five years, in the case of the Navy and the Air Force. Those medical officers who desired retention for a permanent career and who were considered suitable were offered regular commissions, and the others were transferred to the Reserve on the completion of their period on the active list. Under war conditions and during the post war reconstruction period these arrangements were no longer appropriate, and alternative arrangements, adapted to the needs of the individual Services and altered from time to time because of variations in those needs, were adopted. As a result there developed minor differences in practice between the Services but the general position is that short service commissions in all three Services are now of up to eight years' duration. In the Army and the Air Force not less than three years must normally be spent on the active list, while in the Navy the minimum permissible period on the active list is four years as it is also in the case of those doctors, a small minority, who join the Army and the Air Force having already completed national service.

142. National service commissions are for two years only and are normally held by newly qualified doctors who are, in general, inexperienced both from the professional and the Service point of view. The high percentage of such

medical officers employed in the Army, and to a less extent in the Air Force is, as already noted (paragraph 9) inevitably embarrassing. It is obviously desirable that the proportion of short service medical officers should be as high as possible, and that the duration of their stay with the Services should be as long as possible.

143. A fair proportion of newly qualified doctors prefer a three-year short service commission to the two-year national service commission which they would otherwise have to undertake, with a result that the number of medical officers who apply for three-year short service commissions is relatively high. The number who apply for four- five- or six-year commissions is, however, disappointing, due no doubt to the reluctance of those concerned to defer taking up civil work. A secondary cause operating in the same direction is the fact that the conditions of service in the case of short service commissions of four years or longer are substantially less favourable than in the case of three-year short service commissions. We have made proposals elsewhere for correcting this anomaly (paragraph 101). Another factor tending in the same direction is the regulation under which a short service medical officer in the Navy who has completed his four-year term and who is willing to remain on the active list for some time longer is permitted to do so only if he is prepared to undertake a further four-year term. In the case of the Air Force, a short service officer who has completed a four-year term is permitted to extend it year by year, but his liability for service on the Reserve is not correspondingly reduced, with the result that a medical officer who accepts a six-year short service commission is liable for ten years' service in all—six years on the active list and four years on the Reserve—instead of the standard eight years. It seems to us that these and other regulations which tend to curtail the time which an individual with a short service commission may be prepared to spend on the active list should be reviewed and, if possible, modified.

144. It is in our view as we have already said of the first importance that the proportion of medical officers with short service commissions should be maintained at a high level and we hope that all three services will use their best endeavours to that end.

Antedates

145. Representations were made to us that the arrangement introduced on 1st October, 1953, under which an applicant for a regular commission who, after full registration by the General Medical Council, has been engaged in a recognised hospital appointment or in civil practice, is given an antedate which may be for as much as seven years and which counts towards rank, promotion and increments of pay, should be discontinued on the ground that it prejudices the prospects of medical officers already serving. The primary object of this arrangement was to attract into the Service doctors with substantial hospital experience who might be expected to become recognised specialists more quickly than newly qualified recruits, or who might already have acquired the appropriate higher professional qualification and have had so much experience as to warrant their appointment as specialists on entry and so in either event hasten the time when the specialist cadre would be at full strength. The arrangement has met with a fair measure of success and we are of opinion that it should be continued. We anticipate that its effect will be even more fruitful than hitherto as a result of the substantial improvements in pay and prospects which we propose for the specialist section as a whole.

146. The proposal which we make (paragraph 117) that advancement of specialists up to and including the rank of Colonel should be on a service

basis, will, if adopted, in large measure meet the objection raised by existing medical officers to the continuance of this arrangement since their advancement up to the rank of Colonel will be neither imperilled nor delayed by the intrusion of new entrants under the antedate scheme.

147. A secondary aim of the arrangement in question, and one which has been in some measure achieved, was to secure the services of a number of doctors with experience of general practice so as to strengthen the general duty sections of the medical services which in 1953 were carrying an unduly high proportion of newly qualified doctors. Fortunately the position in this regard is now improving and we suggest that this phase of the arrangement, which is inevitably discouraging so far as existing medical officers are concerned, should be kept under review and discontinued as soon as the interests of the Services permit.

Retirement on grounds other than ill-health

148. We have drawn attention elsewhere to the fact that retirement is compulsory in all three Services at ages varying with the rank of the medical officer concerned e.g., 55 in the case of a Surgeon Commander, Lieutenant-Colonel or Wing Commander and 57 in the case of a Surgeon Captain, Colonel or Group Captain. It was represented to us that, since 65 is the normal age of retirement in the National Health Service, Service medical officers are at a grave disadvantage as compared with their civilian colleagues. It is true that a number of Service medical officers retired on age grounds find employment after retirement in Government and other posts, but they do so in competition with civilian doctors. This outlet, though helpful, is limited and has of course no value as a recruiting attraction since it is open to all doctors. The Army have recently introduced an arrangement under which medical officers who are retiring because of age, if professionally competent and otherwise fit, are offered re-employment in a civilian capacity on work which would otherwise have to be undertaken by serving medical officers and for which they receive remuneration over and above their retired pay. This arrangement has the great advantage that it preserves for the Service the specialised experience of the individuals concerned, and at the same time ensures that serving medical officers are of such an age that they can reasonably be expected to be fully mobile. The recruiting value of this scheme has not hitherto been exploited because of the tentative character of the arrangement in question. It seems to us important from the point of view of recruitment that the Army scheme should now be put on a permanent basis and that a new entrant regular medical officer in the Army should, from the outset of his career, be assured that, if and when he is retired on age grounds, he will, if professionally competent and otherwise fit, be offered employment until age 65 in a civilian capacity on work which is the responsibility of the Army. We think that a similar scheme should be adopted by the Air Force. Provision for medical officers retired because of age is more difficult in the Navy because the proportion of medical officers retired in the rank of Surgeon Commander is substantially higher than the proportion retired in the rank of Lieutenant-Colonel or Wing Commander. We think, however, that the Navy ought to adopt so far as possible the same policy in this regard as the Army has done but that any medical officers retired on the ground of age who cannot be provided for by the Navy itself should be found employment elsewhere on Government work. The number of such persons would be so small that it should be easily possible to arrange for their absorption. The terms of re-employment, especially in the matter of pay, should be the same for all three Services.

149. There is another aspect of the retirement position which requires mention. In the case of the Army it is open to a regular medical officer, as to any other regular officer, to retire from the Service at any time that he thinks fit subject to certain conditions and, if he should do so before the normal retiring age, he is entitled to a gratuity provided he has served not less than 10 years and to retired pay if he has served not less than 20 years. This is a long-standing privilege of Army officers and could not, we imagine, be withdrawn from medical officers despite the exceptional terms of their employment. No such privilege exists in the case of Naval and Air Force officers in general or of Naval and Air Force medical officers in particular. Premature retirement may, however, be allowed on compassionate grounds and it is the practice to treat with special consideration applications from officers who are nearing the compulsory retirement age limit and who are anxious to take up employment outside the Service. It was represented to us that the recruitment of Naval and Air Force regular medical officers would be encouraged if the privilege of premature voluntary retirement were extended to them. We greatly doubt whether that would in fact be so and, in any case, feel that the Navy and Air Force would be better without a recruit who, at the outset of his career, concerned himself with the circumstances under which he could escape from the Service if he felt so disposed. We do not recommend any change in the existing practice in the Navy and Air Force.

Preventive Medicine

150. The problems with which the Services are confronted in this regard vary greatly from Service to Service and, as might have been expected, different organisations have been adopted for dealing with them. In the Air Force work of this kind is the responsibility of general duty and administrative medical officers, except in the matter of research, which is undertaken by medical officers graded and paid as specialists. The same is true of the Navy, except that specialists are employed at Commands and at the four major dockyards. In the Army the specialist network is more extensive, specialists being employed at District as well as Command Headquarters.

151. We have already had occasion to observe that the practice of preventive medicine is a fundamental part of every medical officer's job, and have expressed the view that positive steps should be taken to encourage general duty and administrative medical officers to improve their qualifications in this regard and to intensify their interest in the subject. We make proposals to this end (paragraph 111). We feel, on the other hand, that in the case of the Army there is some danger of this work being overspecialised and we take the view that it should be handled up to and including District Headquarters by general duty and administrative medical officers.

152. The Army Health specialist establishment consists of 1 Brigadier, 11 Colonels and 4 Lieutenant-Colonels, all of whom are attached to the War Office or to Command Headquarters, and 41 Majors. Thirty-six of these latter posts are for Deputy Assistant Directors of Army Health at District Headquarters, and the work which is at present undertaken by them ought, in our view, to be merged with general administrative work so far as it cannot be disposed of by general duty medical officers. Three of the other posts for Majors are in the Medical Research Pool and two in the Director of Army Health's branch at the War Office and should be filled by administrative or general duty medical officers who have obtained a Diploma in Public Health or equivalent qualification.

VI. APPLICATION OF SECTIONS I–V TO DENTAL OFFICERS

(A) Introductory

153. The outstanding feature of the dental branches of the Armed Forces is a serious overall shortage of qualified dental officers, which has inevitably resulted in a deterioration in the standard of treatment in the Services. The problem which is paramount for the medical branches, the shortage of fully qualified specialists, is here much less in evidence; although the dental branches do not have as many dental specialists as they require, the numbers needed are not very large and this aspect of the recruitment problem is dwarfed by the much greater deficiencies in the establishments of general duty officers.

154. It is a matter of common knowledge that there is a serious shortage of dentists for the civilian population, though the extent of that shortage has not hitherto been assessed. An Inter-Departmental Committee on Dentistry under the Chairmanship of Lord Teviot reported in 1946 (Command Paper 6727). The Committee found themselves unable to make any precise estimate of the total number of dentists needed for the National Health Service, but they stated that in order to built up to a reasonable figure the intake to the dental schools would have to be about 900 students a year, as compared with the pre-war figure of some 340 a year. This rate has not, in fact, been achieved: it has been falling in the past two or three years and it is now of the order of 450 a year. A Committee under the Chairmanship of Lord McNair has recently been appointed to review the situation.

155. The civilian background of the recruitment of dentists to the Armed Forces is therefore markedly different from that of recruitment of doctors and it was to be expected that recruitment of dentists for the Services would be difficult. It was also to be expected that that difficulty would be increased because the relative attractiveness of a Service career has been reduced as a result of the advantages accruing to civilian dentists as a whole since the establishment of the National Health Service. Both of these expectations have proved to be well founded.

156. The position of the dental branches of the Armed Forces at 31st March, 1955 is shown in the following Table:—

	Total Requirement	Total Strength			
		Numbers	Percentage of		
			Regular	Short Service	National Service
			Per cent.	Per cent.	Per cent.
Navy...	180	96	76	24	—
Army	457	242	29	10	61
Air Force	248	167	33	24	43
Total Armed Forces	885	505	—	—	—

It will be seen that the Navy and Army have about one-half of the total numbers of dental officers they require, while the Air Force has about three-quarters. The very high proportion of national service officers in the Army is particularly disturbing, while that in the Air Force is hardly less so.

The proportion of regular officers in post to the number required is about the same as the proportion of total strength to total establishment in each of the three Services, namely, one-half for the Navy and Army and three-quarters for the Air Force. All three Services have far fewer officers on short service commissions than they need. These deficiencies are particularly serious in that the number of newly-qualified men becoming available each year as a result of their liability for national service falls short of what is required to fill the gaps in the ranks of regular and short service dental officers. The falling intakes into the dental schools in recent years mean that this position will continue for some time to come.

157. The interim measures introduced from 1st October, 1953 (paragraph 1) have on the whole had a favourable effect on recruitment. Before October, 1953, both the Navy and the Army had an excess of loss over intake for both regular and short service officers. Since that date, the Navy has had a net gain in both classes, while the Army has had a net gain in short service officers and a marked reduction in the rate of net loss of regular officers. The Air Force before October, 1953 was able to recruit regular officers in excess of its losses, but had a net loss of short service officers; now it is gaining in the numbers of short service officers but its recruitment of regular officers is just sufficient to offset its losses. The numbers recruited in both categories are, however, small for all three Services and the improvement is far short of what is needed to enable the dental branches to provide a wholly satisfactory standard of treatment. This state of affairs is in our view bound to continue until a nation-wide remedy is found for the present overall shortage of dentists, but in spite of that shortage we feel justified in recommending certain measures which may be expected to result in a restricted improvement in the situation so far as the Armed Forces are concerned, even though it be at the expense of important civilian services.

We have reviewed various ways and means of increasing the relative attractiveness of a career of a dentist in the Services and we have found that, as in the medical branches, the financial aspects of the officer's career are not the most important and therefore we have addressed ourselves to various other aspects of the matter. We treat these in the same order as we have adopted in dealing with the recruiting problem of the medical branches. We first discuss certain general questions of a constitutional nature and then consider in turn the professional aspects of the dental officer's career, the general conditions of Service life, and finally the matter of pay and prospects.

(B) Constitutional

Amalgamation of the Dental Branches of the Forces

158. Although certain witnesses proposed that the dental branches of the three fighting Services should be merged into a common organisation, we found little support for this proposal. The British Dental Association, for example, strongly deprecated it. We have carefully examined the evidence, and conclude that not only would amalgamation of the dental branches do little to solve their present problems but also that it is open to much the same objections as apply to amalgamation of the medical branches, which we have already described (paragraphs 15 to 22). We therefore do not recommend amalgamation of this kind.

Integration with the National Health Service

159. Even in the most favourable conditions, the scope for integration of the dental branches of the Armed Forces with the National Health Service would be much more restricted than it is for the medical branches. As we have shown earlier, it is the large part played by the hospitals, in the

Forces as well as in the civilian medical services, that provides the basis for most of the co-operation between the medical branches of the three Armed Forces and the National Health Service. This basis hardly exists in dentistry where the bulk of the treatment is given in the dentist's surgery and the need for hospital treatment is relatively rare. Integration of the dental branches of the Forces and the National Health Service would therefore largely consist of the provision of dental treatment for men, who are otherwise fit, by civilian dental practitioners operating under the National Health Service. We cannot regard this as an acceptable proposal, as we consider it essential that final responsibility for the dental fitness of serving personnel should rest with the Services themselves.

Co-ordination of Dental Services

160. The Medical Services Co-ordinating Committee (paragraphs 31–33) is responsible for securing co-operation between the dental branches of the Forces. Arrangements for consultation between the Dental Directors of the three Services have been made, although little specific action has been initiated by the Committee, and co-operation between the three dental branches and the National Health Service has been confined mainly to arranging for servicemen on leave to receive treatment through the National Health Service. Not only is the overwhelming importance of individual "out-patient" treatment in the dentist's surgery an inherent limitation on the possibilities of further co-operation, but also the advantages to be gained by dental officers, as well as by patients, as a result of such co-operation are far less marked than they are in medicine. For the great majority of patients, both Service and civilian, satisfactory treatment is provided by the general practitioner dental surgeon in his own surgery. For the dental officer in the Forces, though his range of experience is limited in certain ways, there is not the same necessity for frequent contact with the work of an up-to-date hospital as there is for the medical officer. The aim of co-operation is, therefore, largely one of securing the most economical use of qualified practitioners.

161. It is specially important that no opportunity of using dental officers in the Forces in the best possible way should be neglected, and this must mean some inter-Service co-operation. This, indeed, already exists in the form of one Service assuming responsibility in appropriate cases both at home and overseas for the treatment of personnel of the other two Services where the latter's units are too small to justify the posting of a dental officer of their own. We consider that this arrangement should be extended wherever possible, and recommend that the new co-ordinating committee which we wish to see established (paragraph 44) should include this as one matter requiring attention.

162. In contrast to the medical branches, there is almost no co-operation between the dental branches of the Forces and the National Health Service. This is, as we have already remarked, the almost inevitable result of the relative unimportance of hospital treatment. As against the fairly extensive use of civilian hospitals for treatment of medical cases, the only case of co-operation at hospital level in the Army is that about a dozen Service patients a year are admitted to one civilian hospital where highly specialised oral surgery is available. For more normal dental treatment, the Services do not use the National Health Service. They have however, to employ civilian dentists on an appreciable scale. Servicemen on leave are normally treated by civilian practitioners. Hitherto this has been done on a fee basis and not through the National Health Service, but it has recently been agreed that servicemen on leave should receive emergency treatment through the National Health Service. Further, civilian dentists are employed in

this country, again on a fee basis, for the treatment of personnel at stations and units where a Service dental officer cannot be provided. The Army estimates that about 15,000 military personnel are treated by civilian dentists each year. This use of civilian dentists is forced on the Services as a result of their own shortages of dental officers. This is an expensive and unsatisfactory arrangement as a substitute for a Service dental officer where he could be fully employed in treating patients either from his own Service or from the other two Services. On the other hand, it is obviously desirable where small groups of Servicemen are stationed at a distance from centres where Service dental officers can properly be employed. While we should, therefore, expect an increase in the numbers of dental officers in the Forces to lead to some reduction in the employment of civilian dentists, we regard it as important that civilian dentists should continue to be used wherever this is the most economical method.

163. As is explained later (paragraph 172), specialist services in dentistry are less extensive than they are in medicine. Nevertheless, there is scope for co-operation between Service and civilian dentists at consultant level. In dentistry, as in medicine, the Services at present have perforce to employ civilian specialists and consultants to an extent and in a way which we regard as undesirable. We hope that improved recruitment to the dental branches will in due course help to remedy this unsatisfactory state of affairs. For more normal conditions, we consider it desirable that there should be co-operation between civilian consultants and Service dentists of a kind similar to that which we recommend for doctors (paragraph 42).

Status of Directors of Dental Services

164. It has been suggested to us in evidence that it is unsatisfactory that each of the three Directors of Dental Services should be responsible to the Medical Director-General of his Service and not report directly to the Adjutant-General (or his equivalent in the other two Services). While we take the view that the Director of Dental Services should have access to the Adjutant-General (or his equivalent) when he so wishes, we understand that this is, in fact, the present practice and that the suggested change would have serious disadvantages, and we are unable to support it. Although we do not recommend any change under this particular head we make proposals elsewhere for enhancing the status of dental officers.

Dental Cadetships

165. Several witnesses, including the British Dental Association, proposed the provision of bursaries for suitable candidates for the dental profession on condition that they undertake to enter one of the Services with a permanent commission after qualification. As we have stated in connection with a similar proposal for medical students (paragraphs 47–50), we see grave objections in principle to such an arrangement. Nor do we consider that it would do much to stimulate recruitment to the dental branches of the Forces. There is the same governing consideration as applies to medical students, namely that it is not now usually lack of financial facilities which limits recruitment to the dental profession. We have been confirmed in this view by the evidence of Professor Bradlaw, Dean of the Dental School of the University of Durham, who also informed us that the experience of dental bursaries given by the New Zealand Government has not been encouraging. We, therefore, do not recommend the provision of bursaries of this kind.

(C) Professional

166. Although they do not appear to be such a major deterrent to recruitment as they are for medical officers, we are of the opinion that the limited professional opportunities which the Forces are able to offer in dentistry

do play an important, and under present conditions a discouraging, part in determining whether a recently qualified dentist will decide to make his career in the Services. There is the inevitable limitation placed on dental officers' professional interests by treating mainly young men. To give an example, there can seldom be opportunities to practice orthodontics in children.

167. At the present time, moreover, because of the shortage of dental officers in the Services, the individual officer must perforce spend a great deal of his time in dealing with cases of dental emergency, and, therefore, is unable to devote as much time as he would wish to the more professionally satisfying aspects of his work, such as advanced conservative and preventive procedures. Thus, in spite of the fact that the Services set out to provide for the full range of dental treatment, the dental officer, in reality, has not sufficient time to exercise his professional interests as completely as many are able to do in civilian practice. This situation is bound to continue in some degree so long as dentists generally are in short supply but some easement of it is likely to result from the measures we propose elsewhere for improving the relative attraction of service in the Armed Forces.

168. Service dental officers retire about the age of fifty-five or fifty-seven, and, therefore, are not able to practise their profession for as long a time as their counterparts in the National Health Service, where the normal retiring age is sixty-five. The Services should make available to any dental officer, who so wishes, some form of re-employment after his retirement up to the age of sixty-five in the same way as has been recommended for medical officers.

169. As the dental officer in the Services gains in seniority and reaches the higher ranks, he has to give an increasing amount of his time to administrative work at the expense of his professional interests. The fact that some officers, when the time comes, are willing to do so does not mean that the keen young dentist views this eventual curtailment of his professional opportunities with equanimity. His remedy is to become a specialist and it is therefore important that the specialist should have the promise of a career which is at least as attractive as that of his non-specialist colleagues.

170. In general, it should be the abiding aim of the Service authorities to raise the professional standing of their dental officers within the Service and in the eyes of the civilian profession.

171. Every opportunity, including apparently small ones, should be taken of increasing the scope of dental work available to officers, as well as extending the necessary facilities for doing that work well. In particular, attendance at refresher courses of even a few days' duration, for both short service and regular officers, would be beneficial and should be arranged in spite of the shortage of dental officers.

172. The position in regard to specialists is in need of review. It is true that in Dentistry there is not so clearly marked a differentiation, as in Medicine, between the work of a consultant and that of a general practitioner. Even so, it is essential for the provision of adequate standards of dental treatment that specialist services should be available and that the dental branches should have their own cadres of fully qualified specialists. The availability of an adequate number of dental specialists of accepted standing would raise the professional prestige of the dental branch throughout the Forces. Individual officers should therefore be encouraged to specialise. With this end in view we recommend later (paragraph 184) that the dental officer establishment in the Army and Air Force should be divided

into two sections, a specialist section and a general duty and administrative section in the same way as has been recommended for the medical establishments. We consider that the standards to be attained by a specialist should be comparable to those in the medical branches. In order to become a specialist, an officer should have been qualified at least 7 years and should have had at least 5 years' experience in specialised dental work, such as oral surgery, in particular that carried out in conjunction with maxillo-facial specialists, periodontology, prosthetics and orthodontics. In addition, he should possess an appropriate higher qualification. We further suggest that a candidate for recognition as a specialist, in addition to possessing all the specified requirements, should have to satisfy a special selection board as recommended for the medical branch in paragraph 69.

(D) Service Conditions

173. The evidence which we have received shows olearly that the same elements in Service life which deter doctors from taking up a career in the Services are operative in limiting the recruitment of dentists. We have described these earlier (paragraphs 83–91) and it is unnecessary to repeat them in detail. We therefore content ourselves with a brief comment on each.

Postings

174. Frequency and uncertainty of postings appeared as perhaps the most important factor. Although our evidence for dentists is less complete than that for doctors, as we did not have the advantage of a sample survey similar to that for medical officers, individual serving officers stressed this point. We also had the benefit of an enquiry conducted among about 140 students at a dental school. "Unduly frequent posting" appeared as the most important item among the reasons relating to Service conditions for not seeking permanent commissions. It is perhaps significant that overseas service in itself was unimportant as a reason given by these students. Thus, whatever the facts, it seems clear that the impression that life in the Services is disrupted by frequent postings is an element of outstanding importance in restricting recruitment.

175. The proportion of overseas service to home service is about the same for dentists as for doctors in all three Services, although the dentist usually spends rather more of his time at home than the doctor. It is, of course, necessary that dental officers should serve overseas. We are not satisfied, however, that the present position is satisfactory in regard to unexpected moves during a tour abroad or in the giving of adequate warning to dental officers in this country before they are posted overseas. We, therefore, recommend that dental officers should not normally be moved during their tours abroad, and that they should be given full warning, including information of the precise nature of their posting, before they leave this country for an overseas tour. Frequent re-posting of dental officers in this country should not be necessary, and we recommend that a posting should normally be for not less than three years; longer periods than this should often be possible. Again we stress the importance of adequate warning of all new postings, and of continuous effort to meet the convenience of the particular officer.

Accommodation for Married Officers

176. The shortage of married quarters affects dentists as well as doctors. Dentists also have a long period of training, usually about the same as that of doctors, before they are qualified and can start their careers as commissioned officers in the Forces. They are, therefore, under the same disadvantage as that which we have described earlier, for medical officers

(paragraph 87). We therefore recommend that in the provision of married quarters, dental officers should be placed on an equal footing with combatant officers of the same age and rank.

Children's Education

177. The problem of education of children was brought to our notice by various witnesses, including serving dental officers. The British Dental Association regarded it as of particular importance. We, therefore, draw attention to the need for educational grants and for improved facilities for grammar school education in this country.

Status

178. Every witness from the dental profession who appeared before us was emphatic in deploring the inferior status accorded to dental officers as compared with medical officers in the Armed Forces. This is marked mainly by differences in pay and other emoluments. We do not consider that such differentiation in status is justified in an organised service, and we accordingly regard it as important that, in any changes made to improve the conditions of service in the matters which we have described above, dental officers should be accorded the same treatment as medical officers. Proposals to correct the position so far as emoluments are concerned will be found in paragraphs 181 and 182.

(E) Pay and Prospects*

Pay

179. The evidence put before us in regard to the pay and prospects of dental officers related primarily to the former. The emoluments other than pay, e.g. marriage allowance and retired pay, of a dental officer are identical with those of a medical officer of the same service, age and rank. It was claimed that rates of pay should also be identical.

180. The daily rates of pay (at the minimum for each rank) of medical officers and dental officers respectively are set out below.

	Medical Officers	Dental Officers
	£ s. d.	£ s. d.
Lieutenant	1 6 6	1 4 6
Captain	1 12 6	1 9 6
Major	2 15 0	2 11 0
Lieutenant-Colonel	3 13 0	3 9 6
Colonel	4 15 0	4 11 6
Brigadier†	5 10 0	5 6 6
Major-General	6 0 0	6 0 0

† No dental officers are at present employed in this rank.

It will be seen that the differences between the rates payable to medical officers and to dental officers are small, and it was freely admitted that it was because of considerations of prestige that the claim for equality of pay was pressed so vigorously. These differences are of long standing and can be defended on the ground that the responsibilities of a doctor are, in the nature of things, potentially heavier than those of a dentist. It seems to us, however, that minor differences in remuneration as between professions are to be deprecated in an organised service and we think it is significant that in the National Health Hospital Service and in the Colonial Medical Service, dental officers and medical officers are paid at the same rates.

* Attention is drawn to the Supplementary Note on page 56.

181. We recommend that for the future dental officers should, as in the case of other emoluments, receive the same rates of pay, rank for rank, as medical officers. In making this recommendation, we have had regard to the conclusions reached in paragraph 183 as to the prospects of dental officers. The rates in force before 1st October, 1953, the present, and the proposed remuneration of Army dental officers are set out in Appendices VI and VII.

182. We recommend the following further improvements in the emoluments of dental officers :—

(*a*) The concession proposed in regard to the amounts of the marriage allowance and of the local overseas allowance in the case of national service medical officers (paragraph 105) should apply in the case of national service dental officers.

(*b*) The gratuity payable to short service dental officers, viz., £125 for each completed year of service, should be increased to the same amount as that payable to short service medical officers, viz., £150.

(*c*) The concession in regard to contributions to the National Health Service Superannuation Fund proposed in the case of short service medical officers (paragraph 101) should also apply in the case of short service dental officers.

(*d*) The Permanent Commission Grant payable to regular dental officers should be increased from £1,250 (taxable) to the amount payable to a regular medical officer, viz., £1,500 (taxable).

(*e*) The proposal that medical specialists in the Air Force should in future receive the standard specialist allowance (paragraph 113) should apply in the case of dental specialists also.

(*f*) The proposal that medical officers retired on age grounds should be offered employment in a civil capacity until age 65 (paragraph 148) should apply in the case of dental officers also. Dental officers so employed should receive the same salary as a medical officer of similar standing.

Promotion

183. It was also claimed, though with less conviction, that the prospects of promotion of dental officers should be comparable with those of medical officers. Promotion to Captain and to Major in the Royal Army Dental Corps depends on length of service. The requirements in this regard are the same as in the case of a medical officer, viz., one year and eight years' service respectively. Promotion to Lieutenant-Colonel is, in practice, on the basis of qualified seniority. The same arrangement applies in the case of medical officers and the experience is that medical officer Majors and dental officer Majors are promoted after about the same length of service. The claim to equality of prospects thus relates in effect only to Colonel and higher ranks. The proportion of higher posts available to those who have reached the rank of Lieutenant-Colonel is substantially less for dental than it is for medical officers. This is indeed what we should have expected when account is taken of the respective responsibilities of the two professions, and we have no reason to suppose that the standard applied in assessing the ranks appropriate to posts occupied by senior dental officers is too severe.

We are unable to support this general claim save in one respect. We take the view that, when circumstances permit, a post should be created for a dental consultant in the Army and in the Air Force carrying the rank of Brigadier/Air Commodore.

Specialists

184. We have recommended, in the case of the Army and the Air Force, that the medical officer establishment should be divided into two sections, a specialist section and a general duty and administrative section (paragraph 65). The case for such a division is weaker in regard to the dental officer establishment partly because dental specialists undertake a certain amount of routine dental work and partly because the dental officer establishment is much smaller than the medical officer establishment. The two establishments have, however, hitherto been organised on parallel lines and we anticipate that the Army and the Air Force would prefer that this parallelism should continue. In view of this and of the practice in the National Health Service, we suggest that the dental officer establishment also be split into two sections, that dental specialists receive the same rates of pay and the same specialist allowance as their medical colleagues and that their other conditions of service be brought into alignment with those proposed in the case of medical specialists.

185. We do not propose a separate specialist section for naval medical officers and we recommend that in the case of dental officers, as in the case of medical officers, specialists be included in the general establishment. They should be paid at the rates proposed for medical officer specialists in the Navy (paragraph 130) and their other conditions of service should be brought into line with those proposed for naval medical specialists.

Ancillary Services

186. This Report would not be complete without some mention of the nursing and other ancillary services on whose efficient operation medical and dental officers are so largely dependent. We have already set on foot enquiries as regards these services, but the field is a wide one and we shall not complete our investigations for some time to come. Having regard to the urgent need for action in relation to the recruitment of medical and dental officers we have deemed it inadvisable to delay this Report. We hope to be able to submit our observations and recommendations in regard to the ancillary services about the end of the year.

VII. SUMMARY

Introductory—Section I

(i) Our recommendations in Sections I–V relate to medical officers; dental officers are dealt with in Section VI. (Paragraph 5.)

(ii) The medical branches of the Armed Forces are unable to recruit an adequate number of medical officers on regular and short service commissions, with the result that there is too great a preponderance of national service officers, especially in the Army and Air Force, and a serious shortage of qualified specialists. (Paragraphs 8–12.)

(iii) Attention should be primarily directed to offering a more satisfying professional career to prospective entrants to the medical branches and to improving general conditions of Service life. (Paragraph 13.)

Constitutional—Section II

(iv) Any measure of amalgamation of the three medical branches would be undesirable. (Paragraph 22.)

(v) The Armed Forces should continue to maintain their own hospitals in the United Kingdom and not be integrated with the National Health Service. (Paragraph 30.)

(vi) The integration of Service hospitals into a common service is not recommended, but the joint use of hospitals—particularly specialist hospitals—should be extended. (Paragraph 36.)

(vii) The establishment by the Services of a specialist hospital for traumatic surgery deserves serious consideration. (Paragraph 37.)

(viii) Inter-Service co-ordination in the United Kingdom should be arranged so as to secure that there is no unnecessary duplication of medical facilities. (Paragraph 38.)

(ix) A central research institute is not recommended, but other methods of collaboration on research programmes should be developed. (Paragraph 40.)

(x) The Navy should undertake to treat Service families at Home ports. (Paragraph 41.)

(xi) Civilian and Service hospital staffs should co-operate freely and civilian consultants should pay regular visits to Service hospitals. (Paragraph 42.)

(xii) The employment of paid civilian consultants in place of Service specialists by the Army should be discontinued as soon as possible. (Paragraph 42.)

(xiii) The employment of civilian medical practitioners for the treatment of isolated units and of Servicemen on leave, on a part-time or capitation basis, might be extended. (Paragraph 43.)

(xiv) The establishment of a new and more independent body in place of the present Medical Services Co-ordinating Committee is recommended. If this new body were set up, the need for the existing Advisory Boards in the three Services (but not the National Medical Manpower Committee) would disappear. (Paragraphs 44 and 45.)

(xv) The Medical Directors-General should not be members of the Board of Admiralty or the Army or Air Councils. (Paragraph 46.)

(xvi) The adoption of any scheme of medical cadetships is not recommended. (Paragraph 50.)

(xvii) Women medical officers should be eligible for regular commissions in the Royal Army Medical Corps and for promotion above the rank of Major. (Paragraph 54.)

(xviii) Women doctors should not be made liable for national service, but it is hoped that more women will seek a medical career in the Forces. (Paragraphs 56–57.)

Professional—Section III

(xix) The Service Departments should use every endeavour to raise the professional standing of their medical branches and increase the scope of professional work available to medical officers. (Paragraph 62.)

(xx) There should be a separate specialist section both in the Army and in the Air Force in which officers would continue in their specialist work for the whole of their career and attain the rank of at least Colonel/Group Captain. (Paragraph 65.)

(xxi) It would not be appropriate to introduce a specialist section into the Navy, but time spent at sea by specialists should be reduced to a minimum and specialists promoted to Surgeon Captain should continue to exercise their specialist knowledge and skill. (Paragraph 66.)

(xxii) The Navy and Air Force should bring the professional standards required by their specialists into conformity with those laid down for the Army. (Paragraph 67.)

(xxiii) The secondment to a teaching hospital of medical officers in training to become specialists should be an essential feature of their training. (Paragraph 68.)

(xxiv) Specialists should be recognised only on the recommendation of a board comprising two Service specialists and a leading civilian consultant. (Paragraph 69.)

(xxv) Service specialists should be seconded more often to National Health Service hospitals, and should be afforded opportunities of attending civilian medical conferences and engaging in other professional activities. (Paragraph 71.)

(xxvi) Each Service should make more use of civilian consultants for advice and assistance. (Paragraph 71.)

(xxvii) Junior medical officers with a leaning towards research should be encouraged to engage in it. (Paragraph 72.)

(xxviii) The Services would be benefited if some young doctors, especially those aspiring to specialise, were given longer deferment from national service. (Paragraph 73.)

(xxix) General duty officers should be encouraged, and arrangements made for them, to attend nearby hospitals either Service or civilian and to undertake regular part-time duties there. (Paragraph 76.)

(xxx) Regular and short service medical officers should attend National Health Service refresher courses. (Paragraph 77.)

(xxxi) As a primary task of the medical branches of the Forces lies in the field of preventive medicine, hygiene and public health, regular medical officers, other than clinical specialists, should be encouraged to obtain a Diploma in Public Health or equivalent qualification. (Paragraph 79.)

(xxxii) There is further scope for the employment of non-medical officers in junior staff posts in the Army. The Service Departments should aim at reducing the office work, and increasing the clinical work, of all medical officers. (Paragraph 80.)

Service Conditions—Section IV

(xxxiii) Every effort should be made to give the medical officer adequate warning of home and overseas postings. (Paragraph 85.)

(xxxiv) Medical officers should normally have an expectation of staying in a particular appointment for at least three years. (Paragraph 86.)

(xxxv) The rules for the allocation of married quarters should be revised so as to place medical officers on an equal footing with combatant etc. officers of the same age and rank. (Paragraph 87.)

(xxxvi) The proposal for educational grants in respect of children of Service parents at boarding schools whether stationed at Home or overseas is supported. (Paragraph 90.)

(xxxvii) The co-operation of local education authorities should be sought in the provision of school places for children of Service parents. (Paragraph 91.)

Pay and Prospects—Section V*

(xxxviii) Increases in pay are recommended for all ranks from Major to Brigadier (and equivalent in the other Services); the pay of specialist Colonels and Brigadiers (Group Captains and Air Commodores) should be improved in relation to non-specialists and the ranking of certain senior specialist posts should be reviewed. (Paragraph 92.)

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* Attention is drawn to the Supplementary Note on page 56.

(xxxix) The proposed increases in pay which are made in this Section and in Section VI should take effect from 1st July, 1955. (Paragraph 93.)

(xl) Improvement of pay for Army Lieutenants and Captains and equivalent ranks in the other Services is not recommended. (Paragraph 100.)

(xli) The employer's contribution to the National Health Service Superannuation Fund now payable by a short service medical officer (four or more years) should he defrayed from Service funds. (Paragraph 101.)

(xlii) The existing distinction between the basic pay of national service medical officers and that of regular and short service medical officers should continue (Paragraph 103), but the former should he paid marriage allowance at the same rates as are paid to regular and short service medical officers and he eligible for the "unaccompanied" local overseas allowance. (Paragraph 105.)

(xliii) The existing promotion arrangements in the general duty and administrative section of the Army and Air Force are satisfactory, except that the proportion of Wing Commanders promoted to Group Captain should be increased from 60 per cent. to 75 per cent. (Paragraph 108.)

(xliv) The basic pay of all Majors, Lieutenant-Colonels, Colonels and Brigadiers (and their equivalents) should be increased by 5s. 0d., 6s. 0d., 7s. 0d. and 7s. 0d. per day respectively. (Paragraphs 109 and 128) (for details of recommended rates see Appendices IV and V.)

(xlv) Medical officers below the rank of Colonel and equivalent in all three Services should be granted an allowance of 4s. 0d. per day on obtaining the Diploma in Public Health or comparable qualification. (Paragraph 111.)

(xlvi) The Air Force system of accelerated promotion for specialists should he abandoned in favour of a system of specialist allowances. (Paragraph 113.)

(xlvii) The Air Force should adopt the practice of the Army of paying selected senior trainee specialists 4s. 0d. per day. (Paragraph 114.)

(xlviii) Army and Air Force specialists should be eligible for promotion up to Colonel/Group Captain by length of Service, subject to competence, irrespective of establishment. (Paragraph 117.)

(xlix) Specialist Colonels/Group Captains should receive 12s. 0d. per day specialist allowance. (Paragraph 118.)

(l) Lieutenant-Colonel specialists employed as War Office advisers in certain specialities should be upgraded to Colonel and paid 4s. 0d. per day advisory allowance in addition to normal emoluments. (Paragraph 121.)

(li) Brigadier/Air Commodore specialists should be paid 12s. 0d. per day specialist allowance. (Paragraph 123.)

(lii) Major-General/Air Vice-Marshal specialists should be paid 12s. 0d. per day specialist allowance (Paragraph 124) even though this may in some cases give them more than £6 per day. (Paragraph 125.)

(liii) An Army or Air Force specialist transferred in an exceptional case to administrative duties in the interests of the Service should retain his existing emoluments if they are higher than those of the new post. (Paragraph 126.)

(liv) Non-specialist medical officers in the Navy up to the rank of Surgeon Commander should be given the same improvements in pay as are proposed for the other two Services. (Paragraph 128.)

(lv) As there are no Surgeon Captain specialist posts the maximum of the Surgeon Captain's pay scale should be £5 17s. 0d. per day. Their pay in other respects should be the same as Colonels/Group Captains. (Paragraph 131.)

(lvi) Specialist Surgeon Commanders and Surgeon Lieutenant Commanders should receive the same rates as their opposite numbers in the other Services. (Paragraph 130.)

(lvii) A specialist Surgeon Commander should enter the Surgeon Captain scale, on promotion, at the point next above his existing rate of pay plus specialist allowances. (Paragraph 131.)

(lviii) The practice in the Navy of suspending specialist pay when a medical officer is not posted for specialist duties should be discontinued. (Paragraph 133.)

(lix) The six Command consultants in overseas Army Commands should be upgraded to Brigadier. (Paragraph 136.)

(lx) The Directors of Medicine, Surgery and Army Health at the War Office should be upgraded to Major-General. (Paragraphs 137–138.)

(lxi) The War Office should make an appropriate reduction of administrative Major-General posts when carrying out the upgrading of specialist posts recommended above. (Paragraph 139.)

(lxii) The number of Air Vice-Marshal posts in the Air Force medical branch should be increased from three to five, of which at least two should be for specialists. The view is recorded that the posts of senior consultant in medicine and surgery in any Service are of outstanding importance, and merit recognition by high rank. (Paragraph 140.)

(lxiii) Every endeavour should be made to increase the number of short service officers and to extend their period of service. (Paragraph 142.)

(lxiv) The rules relating to short service commissions should be examined with a view to modifying them so as to encourage medical men who apply for such commissions to spend as long time as possible on the active list. (Paragraph 143.)

(lxv) The present system of antedates for civil hospital experience should continue. (Paragraph 145.)

(lxvi) The system of antedates for officers with experience of civil general practice should be kept under review and discontinued as soon as the needs of the Services permit. (Paragraph 147.)

(lxvii) A regular medical officer on being retired for age from the Army or Air Force should be offered employment in a civilian capacity by those Services, if competent and fit, up to age 65. (Paragraph 148.)

(lxviii) The Navy should arrange for the employment on Government, preferably naval, work of medical officers retired on attaining the age limit. (Paragraph 148.)

(lxix) Army Health posts up to and including Deputy Assistant Directors of Army Health at district headquarters should be filled by general duty officers with a Diploma in Public Health and not by specialists. (Paragraphs 151–152.)

Application of Sections I–V to Dental Officers—Section VI

Introductory

(lxx) There is a serious shortage of qualified dental officers: the Air Force have about three-quarters and the other two Services each about one-half of the total numbers they require, and the numbers of dental officers on short service and regular commissions are especially inadequate. Although the dental profession as a whole is seriously undermanned, it is considered necessary to stimulate recruitment to the dental branches of the Armed Forces. (Paragraphs 156–157.)

Constitutional

(lxxi) Amalgamation of the dental branches is not recommended. (Paragraph 158.)

(lxxii) Treatment of Servicemen by civilian dentists under the National Health Service as a substitute for treatment by dental officers of the Forces is not acceptable. (Paragraph 159.)

(lxxiii) Co-ordination of the dental branches of the Forces should be extended under the care of the new co-ordinating machinery recommended in paragraphs 44–45. (Paragraph 160.)

(lxxiv) Improved recruitment of dental officers should make it possible to reduce the present excessive use by the Services of civilian dental practitioners. (Paragraph 162.)

(lxxv) The employment of paid civilian specialists in place of Service dental specialists should be discontinued as soon as circumstances permit; but co-operation between Service dentists and civilian consultants should be extended wherever possible. (Paragraph 163.)

(lxxvi) It is unnecessary to make any change in the status of the three Directors of Dental Services. (Paragraph 164.)

(lxxvii) Dental bursaries are not recommended. (Paragraph 165.)

Professional

(lxxviii) Dental specialists should have the prospect of a career at least as attractive as that open to non-specialists. (Paragraph 169.)

(lxxix) The professional standing of dental officers should be raised, and the scope of professional work available to them increased. (Paragraphs 170–172.)

(lxxx) Refresher courses for dental officers would be beneficial. (Paragraph 171.)

(lxxxi) The standards to be attained by dental specialists and the method of their selection should be similar to those recommended for medical specialists. (Paragraph 172.)

Service Conditions

(lxxxii) The recommendations for medical officers under this head in regard to (*a*) arrangements for postings, (*b*) allocation of married quarters, and (*c*) educational grants and availability of grammar school places apply equally to dental officers, and it is important that both categories should be given the same treatment. (Paragraphs 174–177 and Summary xxxiii to xxxvii.)

*Pay and Prospects**

(lxxxiii) The pay of dental officers should be the same, rank for rank, as that of medical officers. (Paragraph 181.)

(lxxxiv) There should be improvements in the emoluments of dental officers in respect of (*a*) marriage allowance and local overseas allowance for national service officers, (*b*) gratuity and superannuation fund contibution for short service officers, (*c*) permanent commission grant for regular officers and (*d*) specialist pay, all as in the case of medical officers. (Paragraph 182.)

(lxxxv) Similar arrangements to those recommended for medical officers (paragraph 148) should be made for offering employment up to the age of 65 to regular dental officers who are retired on account of age. (Paragraph 184.)

* Attention is drawn to the Supplementary Note on page 56.

(lxxxvi) The claim for improved prospects of promotion above the rank of Lieutenant-Colonel (and equivalent) for dental officers is not supported except for the creation of one Brigadier post in the Army and one Air Commodore post in the Air Force for dental consultants. (Paragraph 183.)

(lxxxvii) The dental establishment of the Army and Air Force, but not that of the Navy, should be divided into specialist and non-specialist sections. Dental specialists in all three Services should be paid at the same rates as medical specialists. (Paragraphs 184–185.)

We have the honour to be, Sir,

Your obedient Servants,

WAVERLEY (*Chairman*).
HAROLD BOLDERO.
S. R. DENNISON.
T. G. GARDINER.
ARTHUR PORRITT.
J. S. STEELE.

E. P. DONALDSON
J. W. NICHOLAS } *Secretaries.*

2nd September, 1955.

SUPPLEMENTARY NOTE

The Committee's Report was submitted on 2nd September, 1955, and, as pointed out in paragraph 93, its pay proposals were related to comparable rates of remuneration obtaining in the early summer of that year, including the then scales of pay of combatant officers. We have now been informed that those scales are about to be increased and have been invited to say whether, in view of this circumstance, we wish to revise our pay proposals. Particulars of the suggested increases have been disclosed to us and, having regard to their substantial nature, we are of opinion that some upward revision of our original recommendations is warranted. We recommend that the pay which we have proposed in the case of Major, Lieutenant-Colonel, Colonel and Brigadier medical officers should be further increased by 6s. 0d. a day (£109 per annum) at all points of the scales. We recommend in our Report that medical officer Major-Generals on the administrative side should be paid the same rate as combatant Major-Generals and that specialist Major-Generals should be paid in addition an allowance of 12s. 0d. per day. That recommendation still stands. We assume that the Director-General, Army Medical Services, will continue to receive the same remuneration as other Lieutenant-Generals.

The position is exceptional in the case of Lieutenant and Captain medical officers inasmuch as no increase in their pay has been recommended in our Report in view of the fact that their existing remuneration compares favourably with that of combatant officers of similar standing and of doctors in in the corresponding age group in the National Health Service. The increases now proposed in the case of junior combatant officers would raise their pay above that of Lieutenant and junior Captain medical officers. In view of this, we recommend that the pay of Lieutenant medical officers and of

Captain medical officers on appointment be increased by 5s. 6d. a day and that of Captain medical officers after one or two years' service by 7s. 6d. and 6s. 6d. a day respectively. The additions would have the effect of bringing the pay of these medical officers to the same level as that of their combatant colleagues of similar standing. In the case of Captain medical officers other than those referred to above, we recommend the standard increase of 6s. 0d. a day.

The recommendations set out above are intended to apply to Regular and Short Service medical and dental officers in the Navy and Air Force as well as in the Army.

For the Committee,
(Signed) WAVERLEY.

1*st February*, 1956.

APPENDIX I

PRESS NOTICE ISSUED BY THE MINISTRY OF DEFENCE ON 15th SEPTEMBER, 1953

The institution of the National Health Service in the United Kingdom has led to appreciable changes in the structure of professional practice in the medical profession in this country. At the same time, the medical services of the Armed Forces are faced with considerable problems. The current trend of recruiting for permanent regular commissions is disappointing, and applications for these commissions in the medical branches have steadily declined over recent years. Although considerable numbers of newly-qualified doctors due to perform their two years' national service are available for the Services, their service with the Forces is naturally at the beginning of their career when they have not yet had time to acquire the experience of the average practising doctor. There is also a pronounced shortage of specialists, more especially in the Army and Royal Air Force.

2. The Government believe that the problem of providing medical and dental services for the Armed Forces now requires thorough examination in all its aspects. They have therefore decided to set up a small independent committee to advise them on this matter. Its terms of reference will be:—

> "To review the arrangements for providing medical and dental services for the Armed Forces at home and abroad in peace and war; and to make recommendations".

Lord Waverley has agreed to act as Chairman, and the names of the other members will be announced later.

3. The examination of the problem by Lord Waverley's Committee will however take some time, and the Government have therefore decided to give effect to certain immediate steps which it is hoped will result in increased numbers of medical men being attracted to make a career in the Services. These steps fall into two main categories: increases in emoluments, and other administrative measures affecting conditions in the medical branches of the Services and designed to widen their appeal to potential recruits.

4. Improved rates of pay are to be granted to medical officers in the middle ranks, i.e. Major to Brigadier (and the equivalents in the other Services). The increases range from about £90 a year for a Major on first appointment to about £240 a year for a Brigadier. The specialist pay given to senior specialists in the Royal Navy and Army has been increased to about £220 a year: specialists in the Royal Air Force will receive corresponding advantages by accelerated promotion. In addition to these improvements in pay it has been decided, as a temporary measure, to introduce a Permanent Commission Grant of £1,500 (taxable). This will be paid in future to officers granted permanent commissions, payment being subject to the completion of one year's satisfactory service as a medical officer on any type of commission.

5. New provisions in the second category include the following:—

(*a*) There will be a considerable number of posts for retired officers of the medical branches whose services can be effectively used in less active jobs, so as to release younger men for the more active ones.

(*b*) All doctors seeking a permanent career in the Royal Army Medical Corps will be given the opportunity of taking a regular commission on entry, instead of, as hitherto, being required first to take a short-service commission.

(*c*) Late entrants to the medical branches of all three Services, whether on permanent or short-service commissions, will have their seniority as officers antedated, according to their civil experience, up to a maximum of 7 years.

(*d*) The scheme already in operation in the Royal Air Force, for the grant of three-year short-service commissions to doctors with a national service liability, will be extended to the Army.

6. In the dental branches, closely comparable arrangements are being adopted. The increases in pay will range from about £80 p.a. for a Major on promotion to about £230 p.a. for a Brigadier. In addition, it has been decided, as a temporary measure, to introduce a Permanent Commission Grant of £1,250 (taxable); this will he paid in future to officers granted permanent commissions, payment being subject to the completion of one year's satisfactory service as a dental officer on any type of commission.

7. The interim measures set out above will be brought into force from 1st October, 1953.

APPENDIX II

LIST OF ORGANISATIONS AND INDIVIDUALS FROM WHOM ORAL OR WRITTEN EVIDENCE WAS RECEIVED

British Medical Association.

British Dental Association.

The Conference of Deans of the Metropolitan Teaching Hospitals.

The Medical Women's Federation.

The Pharmaceutical Society of Great Britain.

British Chapter of the American Academy of Optometry.

Joint Emergency Committee (Optical Profession).

The Institute of Professional Civil Servants.

The Lord Haden-Guest, Chairman, Medical Manpower Committee.

The Lord Nathan.

Dr. J. A. MacFarlane, Chairman, Canadian Forces Medical Council.

The Lord Moran, Army Medical Advisory Board.

Dr. E. Cullinan, Army Medical Advisory Board.

Dr. E. R. Boland, Army Medical Advisory Board.

Lieutenant-General Sir Alexander Hood (Governor of Bermuda, formerly Director-General, Army Medical Services).

Lieutenant-General Sir Neil Cantlie (formerly Director-General, Army Medical Services).

Professor J. H. Biggart, Dean of the Medical Faculty, The Queen's University, Belfast.

Air Marshal Sir Philip Livingston (formerly Director-General, Medical Services, R.A.F.).

Dr. J. G. Macrie, Chairman of the Conference of Deans of English Provincial Medical Schools.

Mr. R. Atkinson Stoney, Dean of the Medical School, University of Dublin.

Mr. H. H. G. Eastcott, Surgeon, St. Mary's Hospital, Paddington.

Colonel D. C. Bowie, British Post-Graduate Medical Federation, University of London.

Air Marshal Sir Harold Whittingham (formerly Director-General, Medical Services, R.A.F.).

Professor C. Wilkinson, Dean and Director of Studies, Institute of Dental Surgery, University of London.

Professor R. V. Bradlaw, Dean of the Dental School, University of Durham.

APPENDIX III

LIST OF GOVERNMENT DEPARTMENTS AND AUTHORITIES WHO FURNISHED INFORMATION

Treasury	
Ministry of Defence	Mr. A. J. Newling, Chairman, Medical Services Co-ordinating Committee.
Commonwealth Relations Office ...	Lieutenant-General Sir Bennett Hance, Medical Adviser to the Secretary of State.
Colonial Office	Sir Eric Pridie, Chief Medical Officer. Mr. E. R. Edmonds, Assistant Secretary.
Admiralty	Surgeon Vice-Admiral Sir Alexander Ingleby-Mackenzie, Medical Director-General of the Navy. Mr. J. Lawson, Under-Secretary. Surgeon Rear-Admiral F. R. P. Williams, Deputy Director-General, Naval Dental Service.
War Office	Lieutenant-General Sir Frederick Harris, Director-General, Army Medical Services. Mr. C. E. Key, Deputy Under-Secretary of State. Major-General J. Wren, Director, Army Dental Service.
Air Ministry	Air Marshal Sir James Kilpatrick, Director-General, Medical Services. R.A.F. Mr. A. E. Slater, Assistant Under-Secretary of State. Air Vice-Marshal G. A. Ballantyne Director, R.A.F. Dental Service.
Ministry of Health	Sir John Charles, Chief Medical Officer. Mr. J. P. Dodds, Under-Secretary. Dr. W. G. Senior, Principal Dental Officer.
Board of Inland Revenue	Mr. E. R. Brookes, Commissioner and Secretary.

APPENDIX IV

ROYAL ARMY MEDICAL CORPS—NON-SPECIALIST MEDICAL OFFICERS

Rank and Service	Pay (Daily Rate)			Proposed Yearly Emoluments (Married)				Increase in Total Emoluments	
	Before 1st Oct., 1953	Present	Proposed*	Pay†	Marriage Allowance	Ration Allowance (grossed for tax)	Total†	On pre-1st Oct., 1953 Rates†	On present Rates†
	£ s. d.	£ s. d.	£ s. d.	£	£	£	£	£	£
Lieutenant	1 6 6	1 6 6	1 6 6	484	338	128	950	—	—
Captain	1 12 6	1 12 6	1 12 6	593	338	128	1,059	—	—
After 2 years	1 15 6	1 15 6	1 15 6	648	338	128	1,114	—	—
After 3 years	1 18 0	1 18 0	1 18 0	693	338	128	1,159	—	—
After 4 years	2 1 0	2 5 0	2 5 0	821	338	128	1,287	73	—
After 6 years	2 4 0	2 8 0	2 8 0	876	338	128	1,342	73	—
Major	2 10 0	2 15 0	3 0 0	1,095	338	128	1,561	182	91
After 2 years	2 13 0	3 1 0	3 6 0	1,204	338	128	1,670	237	91
After 4 years	2 16 0	3 7 0	3 12 0	1,314	338	128	1,780	292	91
After 6 years	2 19 0	3 10 0	3 15 0	1,369	338	128	1,835	292	91
Lieutenant-Colonel ...	3 6 0	3 13 0	3 19 0	1,442	383	128	1,953	237	109
After 2 years	3 9 0	3 19 0	4 5 0	1,551	383	128	2,062	292	109
After 4 years	3 12 0	4 5 0	4 11 0	1,661	383	128	2,172	347	109
After 6 years	3 15 0	4 8 0	4 14 0	1,715	383	128	2,226	347	109
After 8 years	3 18 0	—	—	—	—	—	—	—	—
Colonel	4 5 0	4 15 0	5 2 0	1,861	383	128	2,372	310	128
After 2 years	4 8 0	4 18 0	5 5 0	1,916	383	128	2,427	310	128
After 4 years	4 11 0	5 1 0	5 8 0	1,971	383	128	2,482	310	128
After 6 years	4 14 0	5 4 0	5 11 0	2,026	383	128	2,537	310	128
Brigadier	4 17 0	5 10 0	5 17 0	2,135	429	128	2,692	365	128
Major-General‡	6 0 0	6 0 0	6 0 0	2,190	474	128	2,792	—	—
Lieutenant-General‡ ...	7 10 0	7 10 0	7 10 0	2,737	474	128	3,339	—	—

* In accordance with the Supplementary Note on page 56, the rates in this column should be increased by 5s. 6d. for Lieutenants and Captains on appointment, by 6s. 6d. for Captains after 2 years and by 6s. at all other points up to and including Brigadier.

† The effect of the proposals in the above note would be to increase the amounts in these columns by £100 for Lieutenants and Captains on appointment, by £119 for Captains after 2 years, and by £109 at all other points up to and including Brigadier.

‡ For the pay of these ranks refer to the Supplementary Note on page 56.

APPENDIX V

ROYAL ARMY MEDICAL CORPS—SPECIALIST MEDICAL OFFICERS

Rank aod Service	Pay and Specialist Pay (Daily Total)			Proposed Yearly Emolumcots (Married)				Increase in Total Emoluments	
	Before 1st Oct., 1953	Present	Proposed*	Pay and Specialist Pay†	Marriage Allowance	Ration Allowance (grossed for tax)	Total†	On pre-1st Oct., 1953 Rates†	On present Rates†
	£ s. d.	£ s. d.	£ s. d.	£	£	£	£	£	£
Lieutenant	1 6 6	1 6 6	1 6 6	484	338	128	950	—	—
Captain	1 12 6	1 12 6	1 12 6	593	338	128	1,059	—	—
After 2 years	1 19 6	1 19 6	1 19 6	721	338	128	1,187	—	—
After 3 years	2 2 0	2 2 0	2 2 0	766	338	128	1,232	—	—
After 4 years	2 5 0	2 9 0	2 9 0	894	338	128	1,360	73	—
After 6 years	2 8 0	2 12 0	2 12 0	949	338	128	1,415	73	—
Major	2 18 0	3 7 0	3 12 0	1,314	338	128	1,780	255	91
After 2 years	3 1 0	3 13 0	3 18 0	1,423	338	128	1,889	310	91
After 4 years	3 4 0	3 19 0	4 4 0	1,533	338	128	1,999	365	91
After 6 years	3 7 0	4 2 0	4 7 0	1,588	338	128	2,054	365	91
Lieutenant-Colonel ...	3 14 0	4 5 0	4 11 0	1,661	383	128	2,172	310	109
After 2 years	3 17 0	4 11 0	4 17 0	1,770	383	128	2,281	365	109
After 4 years	4 0 0	4 17 0	5 3 0	1,880	383	128	2,391	420	109
After 6 years	4 3 0	5 0 0	5 6 0	1,934	383	128	2,445	420	109
After 8 years	4 6 0	—	—	—	—	—	—	—	—
Colonel	4 5 0	5 1 0	5 14 0	2,080	383	128	2,591	529	237
After 2 years	4 8 0	5 4 0	5 17 0	2,135	383	128	2,646	529	237
After 4 years	4 11 0	5 4 0	6 0 0	2,190	383	128	2,701	529	292
After 6 years	4 14 0	5 4 0	6 3 0	2,245	383	128	2,756	529	347
Brigadier	4 17 0	5 10 0	6 9 0	2,354	429	128	2,911	584	347
Major-General‡	6 0 0	6 0 0	6 12 0	2,409	474	128	3,011	219	219

* In accordance with the Supplementary Note on page 56, the rates in this column should be increased by 5s. 6d. for Lieutenants and Captaios on appointment, by 6s. 6d. for Captains after 2 years and by 6s. at all other points up to and including Brigadier.

† The effect of the proposals in the above note would be to increase the amounts in these columns by £100 for Lieuteoants and Captains on appointment, by £119 for Captains after 2 years, and by £109 at all other points up to and including Brigadier.

‡ For the pay of this rank refer to the Supplementary Note on page 56.

APPENDIX VI

ROYAL ARMY DENTAL CORPS—NON-SPECIALIST DENTAL OFFICERS

Rank and Service	Pay (Daily Rate)			Proposed Yearly Emoluments (Married)				Increase in Total Emoluments	
	Before 1st Oct., 1953	Present	Proposed*	Pay†	Marriage Allowance	Ration Allowance (grossed for tax)	Total†	On pre-1st Oct., 1953 Rates†	On present Rates†
	£ s. d.	£ s. d.	£ s. d.	£	£	£	£	£	£
Lieutenant	1 4 6	1 4 6	1 6 6	484	338	128	950	36	36
Captain	1 9 6	1 9 6	1 12 6	593	338	128	1,059	55	55
After 2 years	1 12 6	1 12 6	1 15 6	648	338	128	1,114	55	55
After 3 years	1 15 0	1 15 0	1 18 0	693	338	128	1,159	55	55
After 4 years	1 18 0	2 2 0	2 5 0	821	338	128	1,287	128	55
After 6 years	2 1 0	2 5 0	2 8 0	876	338	128	1,342	128	55
Major	2 7 0	2 11 6	3 0 0	1,095	338	128	1,561	237	155
After 2 years	2 10 0	2 17 6	3 6 0	1,204	338	128	1,670	319	155
After 4 years	2 13 0	3 3 6	3 12 0	1,314	338	128	1,780	347	155
After 6 years	2 16 0	3 6 6	3 15 0	1,369	338	128	1,835	347	155
Lieutenant-Colonel ...	3 3 0	3 9 6	3 19 0	1,442	383	128	1,953	319	174
After 2 years	3 6 0	3 15 6	4 5 0	1,551	383	128	2,062	347	174
After 4 years	3 9 0	4 1 6	4 11 0	1,661	383	128	2,172	501	174
After 6 years	3 12 0	4 4 6	4 14 0	1,715	383	128	2,226	501	174
After 8 years	3 15 0	—	—	—	—	—	—	—	—
Colonel	4 2 0	4 11 6	5 2 0	1,861	383	128	2,372	365	191
After 2 years	4 5 0	4 14 6	5 5 0	1,916	383	128	2,427	365	191
After 4 years	4 8 0	4 17 6	5 8 0	1,971	383	128	2,482	365	191
After 6 years	4 11 0	5 0 6	5 11 0	2,026	383	128	2,537	365	191
Brigadier	4 14 0	5 6 6	5 17 0	2,135	429	128	2,692	420	191
Major-General‡	6 0 0	6 0 0	6 0 0	2,190	474	128	2,792	—	—

* In accordance with the Supplemcntary Note on page 56, the rates in this column sbould be increased by 5s. 6d. for Lieutenants and Captains on appointment, by 6s. 6d. for Captains after 2 years and by 6s. at all other points up to and including Brigadier.

† The effect of the proposals in the above note would be to increase tbe amounts in these columns by £100 for Lieutcnants and Captains on appointment, by £119 for Captains after 2 years, and by £109 at all other points up to and including Brigadier.

‡ For the pay of this rank refer to the Supplementary Note on page 56.

(83631) Wt. 1284—1010 K18 3/56 D.L.

APPENDIX VII

ROYAL ARMY DENTAL CORPS—SPECIALIST DENTAL OFFICERS

Rank and Service	Pay and Specialist Pay (Daily Total)			Proposed Yearly Emoluments (Married)				Increase in Total Emoluments	
	Before 1st Oct., 1953	Present	Proposed*	Pay and Specialist Pay†	Marriage Allowance	Ration Allowance (grossed for tax)	Total†	On pre-1st Oct., 1953 Rates†	On present Rates†
	£ s. d.	£ s. d.	£ s. d.	£	£	£	£	£	£
Lieutenant	1 4 6	1 4 6	1 6 6	484	338	128	950	36	36
Captain	1 9 6	1 9 6	1 12 6	593	338	128	1,059	55	55
After 2 years	1 16 6	1 16 6	1 19 6	721	338	128	1,187	55	55
After 3 years	1 19 0	1 19 0	2 2 0	766	338	128	1,232	55	55
After 4 years	2 2 0	2 6 0	2 9 0	894	338	128	1,360	128	55
After 6 years	2 5 0	2 9 0	2 12 0	949	338	128	1,415	128	55
Major	2 15 0	3 3 6	3 12 0	1,314	338	128	1,780	310	155
After 2 years	2 18 0	3 9 6	3 18 0	1,423	338	128	1,889	365	155
After 4 years	3 1 0	3 15 6	4 4 0	1,533	338	128	1,999	420	155
After 6 years	3 4 0	3 18 6	4 7 0	1,588	338	128	2,054	420	155
Lieutenant-Colonel ...	3 11 0	4 1 6	4 11 0	1,661	383	128	2,172	365	174
After 2 years	3 14 0	4 7 6	4 17 0	1,770	383	128	2,281	420	174
After 4 years	3 17 0	4 13 6	5 3 0	1,880	383	128	2,391	474	174
After 6 years	4 0 0	4 16 6	5 6 0	1,934	383	128	2,445	474	174
After 8 years	4 3 0	—	—	—	—	—	—	—	—
Colonel	4 2 0	4 17 0	5 14 0	2,080	383	128	2,591	584	310
After 2 years	4 5 0	5 0 6	5 17 0	2,135	383	128	2,646	584	310
After 4 years	4 8 0	5 0 6	6 0 0	2,190	383	128	2,701	584	354
After 6 years	4 11 0	5 0 6	6 3 0	2,245	383	128	2,756	584	410
Brigadier	4 14 0	5 6 6	6 9 0	2,354	429	128	2,911	638	410

* In accordance with the Supplementary Note on page 56, the rates in this column should be increased by 5s. 6d. for Lieutenants and Captains on appointment, by 6s. 6d. for Captains after 2 years and by 6s. at all other points up to and including Brigadier.

† The effect of the proposals in the above note would be to increase the amounts in these columns by £100 for Lieutenants and Captains on appointment, by £119 for Captains after 2 years, and by £109 at all other points up to and including Brigadier.